

Zero Protection

How U.S. Border Enforcement Harms Migrant Safety and Health

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*Cover: Migrants surrender to U.S. Border Patrol agents after jumping over the metal barrier at Tijuana, Mexico in December 2018.
Photo: Guillermo Arias/AFP/Getty Images*

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Executive Summary

Public health research has documented widening racial and ethnic health disparities as a result of punitive and discriminatory immigration enforcement practices within the militarized border zone.

Over the past three decades, U.S. administrations from both parties have introduced border enforcement strategies that have led to the deaths or injuries of a growing number of migrants at the U.S.-Mexico border. Public health research has documented widening racial and ethnic health disparities as a result of punitive and discriminatory immigration enforcement practices within the militarized border zone. This policy brief provides an analysis of current concerns at the border, including ways that health professionals are implicated in human rights violations, and provides recommendations for the U.S. government and for health systems to protect the rights and health of migrants.

Physicians for Human Rights (PHR) analyzed documentation with respect to several ongoing areas of harmful practices arising from border enforcement activities and found numerous human rights violations, including that:

1. Despite the existence of the U.S. Customs and Border Protection (CBP) *Use of Force Policy, Guidelines and Procedures Handbook*, migrants are still being injured and killed in the course of enforcement activities;
2. CBP officials impede and criminalize volunteer first responders who are providing lifesaving assistance to migrants in the field by arresting them and filing federal charges against them;
3. CBP officials have been documented destroying humanitarian assistance;
4. CBP officials have used medical personnel to conduct body searches without warrants or consent;
5. In violation of U.S. asylum law, CBP is preventing asylum seekers from crossing legally at ports of entry, and deporting individuals with medical conditions through official ports of entry without having secured safe medical release; and
6. CBP's law enforcement arm, the U.S. Border Patrol (USBP), conducts enforcement actions in and around hospitals, in violation of the Sensitive Locations policy, and violates U.S. and international law by using hospitals as de facto detention centers where patients are denied access to legal counsel and contact with family members.

In summary, CBP officials regularly misinterpret or even disregard the limits of their legal authority while conducting border enforcement activities, constituting human rights violations and resulting in harms to health.

PHR calls on the CBP to improve staff compliance with existing border enforcement guidelines by clarifying guidelines and improving training, as well as investigating and sanctioning all violations committed by personnel. CBP must also work with civil society groups operating at the border in order to prevent fatalities and decrease health risks. The U.S. Congress can support rights-respecting border management by codifying existing CBP operational guidelines into law, and exercising oversight over the Department of Homeland Security and its agencies in regard to compliance with legal obligations.

Introduction

Overview

This policy brief combines individual interviews conducted by PHR staff and board members and reports from a range of civil society organizations and open media sources with a review of forensic, medical, and public health research related to border enforcement, health, and human rights. From June to October 2018, PHR engaged in a series of consultations with groups and individuals at the U.S.-Mexico border during visits by PHR staff, board members, and volunteer medical experts. PHR teams traveled to Brownsville, McAllen, Alamo, Houston, El Paso, and Sierra Blanca in Texas, and Tucson and Arivaca in Arizona in order to assess possible human rights violations at the U.S.-Mexico border. In total, PHR met with 18 organizations working at the border, speaking with more than 60 individuals in total. Interlocutors included immigration attorneys and paralegals, physicians, social workers, EMTs, nurses, human rights activists, immigration detention facility staff, detained immigrants, asylum seekers waiting at ports of entry, U.S. Customs and Border Protection agents at ports of entry, and local border community members. In Tucson, PHR held a consultation workshop with 11 experienced border activists representing six organizational and institutional affiliations in order to deepen and validate our analysis. This preliminary analysis suggests key areas of concern that require more in-depth and rigorous research to systematically document the prevalence and impact of human rights violations occurring in the context of border enforcement.

The Relationship between Border Control and Human Rights

Customs and Border Protection officials impede and criminalize volunteer first responders who are providing lifesaving assistance to migrants.

According to U.S. government interpretation in the post-WWII period, basic constitutional protections are not fully applicable within 100 miles of the U.S. border; however, this interpretation has not been subjected to meaningful review in Congress.¹ Since migration is a global issue, it is instructive to measure U.S. government interpretation of state obligations against international standards. Border enforcement agencies ensure the orderly, safe, and humane movement of people across borders, while the law enforcement function of border control can also protect rights by dismantling transnational criminal networks engaged in smuggling or trafficking.² On the other hand, border control policies can also inflict or exacerbate human rights abuses. For example, state criminalization of irregular migration is linked with increased vulnerability to smuggling, extortion, kidnapping, or trafficking.³

Although there are no legally binding international standards for border governance, the United Nations has developed guidelines to clarify states' obligations as they apply to border governance under existing human rights instruments. The guidelines emphasize core human rights principles such as the right to non-discrimination, due process, non-refoulement (the right to not be returned to a country of origin in which

persecution is likely), best interests of the child, and the state obligation to provide protection.⁴ States have an obligation to strengthen rescue capacity and protect individuals from harm during rescue.⁵ Excessive use of force is prohibited, delays at crossing points should be minimized, and appropriate humanitarian assistance should be provided during delays at ports of entry.⁶ Border personnel should be trained, and any violations of agency policies and guidelines should be investigated and sanctioned.⁷ These basic humanitarian standards, which are consistent with United States constitutional principles, should be seriously considered for informing comprehensive reform of U.S. border policy.

Borders in Context: In the United States and Globally

The geographical terrain along the U.S.-Mexico border is harsh; much of it is desert, where wildly variable temperatures reach as high as 118 degrees Fahrenheit in summer months, with daily variations of up to 59 degrees.⁸ Natural clean water sources are scarce, and rivers have strong currents which makes them dangerous to cross.⁹ According to U.S. Border Patrol estimates, from 1998 to 2015, more than 6,500 migrants died on the U.S. side of the border, with an annual rate of approximately 250 to 500 migrant deaths; the International Organization for Migration (IOM) estimates a similar number, with at least 320 migrant deaths along the border in 2015.¹⁰ The majority of deaths are related to exposure to the elements, with one study based on coroners' reports estimating that deaths due to environmental heat exposure represent approximately 73 percent of deaths of migrants crossing between ports of entry, followed by vehicle crashes (eight percent) and drownings (six percent).¹¹ Sporadic efforts to strengthen search and rescue capacity are insufficient.¹²

Deaths of migrants at the U.S. border are part of a worrisome trend worldwide. When states withdraw from search and rescue operations and impede civil society rescue efforts, more migrants die.¹³ The IOM estimates that in the past 20 years, more than 60,000 migrants globally have died while crossing borders, many of whom are never found or identified.¹⁴ As in the United States, European authorities are prosecuting NGOs operating rescue activities¹⁵ and criminalizing assistance to migrants,¹⁶ including restricting delivery of food and water to migrants.¹⁷ Migrants in Europe as well as the United States are vulnerable to violence by community members and even by state agents. A study by Médecins Sans Frontières (MSF) found that almost one third of migrant and refugee patients in MSF clinics in northern Europe had suffered physical violence in transit through the Balkans – with local authorities, rather than protecting migrants, actually directly perpetrating more than half of the assaults.¹⁸

Why Are Migrants Dying?

“A young man detained at the border was bitten by a rattlesnake, but Border Patrol didn’t believe him. They brought him to the detention center for two days, where he started manifesting acute symptoms and was then in the hospital for a week.”

Claire Lamneck, medical student at the University of Arizona and border activist

U.S. Border Enforcement Policies are Linked with Rising Death Rates

Starting in the mid-1990s, U.S. Border Patrol initiated a policy of “prevention through deterrence,” militarizing border areas in order to funnel migrants into more remote and impassable areas. According to the 1994 U.S. Border Patrol Strategic Plan, changes to enforcement infrastructure and practices would ideally “force [migrants to cross] over more hostile terrain, less suited for crossing and more suited for enforcement.”¹⁹ According to both U.S. government experts²⁰ and academic analyses of medical examiners’ records,²¹ this policy is connected with a 100 percent increase in the annual number of migrant deaths on the border. A University of Houston study of migrant crossing deaths from 1985 to 2000, comparing before and after the “prevention through deterrence” policy, found that the only period when deaths decreased was in the late 1980s, after the legalization of the status of more than two million undocumented immigrants allowed immigrants to cross through legal channels.²² Prevention through deterrence, both by natural hazards and also through criminalization and incarceration, has increased the risk of harm to migrants.

At the same time, these policies have not been demonstrated to be effective in deterring migrants from attempting to cross into the United States,²³ nor has “tactical infrastructure,”— walls, gates, grates, and roads – made unauthorized crossing impossible.²⁴ Border crossers do not stop crossing, but simply face increased risks of serious injury and death. Epidemiological analysis of injuries from falling from a border fence demonstrated a significant increase in the number of injured crossers after the San Diego border fence was reinforced in the late 1990s; from 2000 to 2007, injuries increased from 3.34 to 24.96 for every 100,000 apprehensions.²⁵ In southern Arizona, emergency medical teams refer to the path by the border wall as “the ankle alley,” due to the high number of trauma patients with orthopedic injuries such as lower-extremity and spinal fractures.²⁶

Border Agents’ Use of Lethal Force is Hidden from Accountability

In addition to the higher risk of deaths due to the harsh terrain, U.S. Border Patrol operational practices themselves are likely to increase the risk of death. Use of lethal force by U.S. Border Patrol agents has resulted in the deaths of as many as 97 people over the last 15 years on both sides of the border, yet investigations into killings by

Border Patrol agents are not reported publicly, evading institutional oversight and accountability.²⁷ Since 2010, watchdog groups have documented 77 Customs and Border Protection (CBP)-related fatalities – at least one fifth of them of U.S. citizens.²⁸ Media reports have raised issues about the circumstances in which force is used against unarmed migrants.²⁹ CBP is resistant to civil society scrutiny; a Cato Institute Freedom of Information Act request to CBP filed in 2015, which requests more detail about use of force incidents, has been on administrative appeal for two years.³⁰ In 2016, the Homeland Security Advisory Council determined that CBP disciplinary processes for agent violations were too slow to be effective deterrents, requiring increased training for agents on the use of nonlethal force.³¹

Border Patrol High-speed Chases Cause Injuries and Death

Community groups have also voiced serious concerns about excessive force resulting in injury and death caused by Border Patrol's preferred apprehension methods, which may be characterized as "weaponizing" the terrain.³² Use of helicopters, SUVs, ATVs, horses, dogs, and Tasers in chases over rough terrain have been reported to cause serious injuries and deaths, especially when combined with insufficient efforts to locate those wounded during the chase.³³ Chases during the night are particularly dangerous, as those being chased cannot see where they are running. Medical volunteers have documented severe foot injuries as well as serious blunt-force trauma from falling on rocks or off cliffs.³⁴ Chases also increase the likelihood that those who are chased may be separated and find themselves alone, disoriented, and without supplies to survive. Chasing migrants back into dangerous water crossings, where the risk of drowning is increased due to exhaustion from being pursued by agents, is another cause of death documented by local groups.³⁵ Said one rancher in Arizona: "It is kinda like a sick prison movie. [Border Patrol] let [migrants] come across and then chase them until they drop. That's what kills a lot of people."³⁶

Border Patrol Agents Destroy Humanitarian Assistance

"Dehydration is the most common cause of migrant deaths... This past year, the human remains of 123 people were found in the desert near southern Arizona, but we know that many more die and are undiscovered. Volunteer organizations ... place water out in the desert to prevent deaths, despite many gallons being destroyed by U.S. Border Patrol agents."

Norma Price, MD, PHR Asylum Network member and Tucson Samaritans medical advisor

Every year, hundreds of people die of dehydration and hypothermia in the desert on the U.S.-Mexico border, yet agents in the field prioritize enforcement over lifesaving assistance. Community groups have documented widespread intentional vandalism and destruction of water, food, and blankets left for migrants in the desert, particularly at points in the terrain where border crossers are unlikely to survive without such assistance.³⁷ From 2012 to 2015, humanitarians recorded a total of 3,586 vandalized gallon jugs of water, slashed with knives and emptied.³⁸ They logged

a total of 415 incidents of vandalism, averaging two per week, and recorded agents on video destroying water jugs as recently as 2017.³⁹ In addition to slashed and emptied water jugs, humanitarian groups have also documented vandalism of food cans which are emptied or stabbed so the food spoils.⁴⁰ Although official Border Patrol policy does not condone intentional destruction of food and water, no sanctions have been implemented against agents who have been documented destroying humanitarian aid, which may amount to tacitly condoning the practice, especially if it may be seen as furthering the goal of “prevention through deterrence.”⁴¹

From 2012 to 2015, humanitarians recorded a total of 3,586 vandalized gallon jugs of water, slashed with knives and emptied... and recorded agents on video destroying water jugs as recently as 2017.

Border Patrol Agents Arrest Medical First Responders and Interrupt Medical Treatment

Volunteers in community groups have been subjected to criminal prosecution for providing medical and other lifesaving assistance to migrants.⁴² For example, nine volunteers of a local group that provides water, food, and medical care to migrants in the desert were charged with federal crimes and misdemeanors in 2017, mostly “littering.”⁴³ In 2007 and 2008, eight humanitarian volunteers were detained by Border Patrol on federal charges of “littering” for leaving water jugs in the desert.⁴⁴ Humanitarian volunteers report that Border Patrol agents have threatened physical violence and arrest, subjected them to aggressive interrogation, forced volunteers’ vehicles off the road, and brandished their firearms.⁴⁵

Border agents have also been documented overtly interfering with potentially life-saving medical treatment by arresting individuals suspected to be unauthorized migrants while they were receiving medical treatment in the field for injuries sustained while crossing the desert.⁴⁶ In a 2017 tactical raid involving 30 agents, 15 trucks, and a helicopter, Border Patrol arrested four migrants receiving medical care during a record heat wave.⁴⁴ The ACLU documented instances in several New Mexico communities where CBP stopped and demanded to search ambulances and impeded and interrogated first responders who were providing emergency treatment to patients, jeopardizing the health of the patients and increasing the risk of negative health outcomes.⁴⁷ A 10-year-old girl with cerebral palsy was arrested by CBP agents in an ambulance heading towards the hospital for her emergency gallbladder surgery.⁴⁸ These cases represent a disproportionate and unnecessary exercise of discretionary authority, which puts patients at unknown risk and obstructs the ethical duty of health professionals to provide medical care.

Search without Rescue: When 911 Is Border Patrol

In some border counties, people calling 911 for emergency medical services from the borderlands are automatically re-directed to Border Patrol Search, Trauma, and Rescue.

Walking for days through the harsh desert environment without water, border crossers regularly need urgent medical assistance. Common ailments requiring hospitalization include severe dehydration, injuries to the legs and feet, gastrointestinal illness from contaminated water, poisonous animal bites, and ingestion of cactus.⁴⁹ An investigation of 55 border crossers admitted to intensive care units in southern Arizona from 2010 to 2012 showed that the most common diagnoses for those crossing in the desert were physical trauma injuries, rapid muscle dissolution, acute liver injury, dehydration, acute kidney injury, brain damage, and respiratory failure.⁵⁰ These health complications may also be found in patients far from the border, who have rejoined family or friends without receiving adequate medical care after their grueling journey.⁵¹

However, in some border counties, people calling 911 for emergency medical services from the borderlands are automatically re-directed to Border Patrol Search, Trauma, and Rescue (BORSTAR), the search and rescue unit of Border Patrol. BORSTAR agents are Border Patrol agents who volunteer to complete additional training, including EMT certification.⁵² Callers are not informed that their call has been re-directed to immigration authorities. In some counties, emergency calls are not even sent to BORSTAR, but directly to regular Border Patrol agents.⁵³

While search and rescue and calls for emergency assistance should be completely separate from border enforcement in order to safeguard the delivery of care, in some border counties these functions are combined. Moreover, even when there is an effort to separate them, there is a lack of coordination and oversight. Within the current system, those in emergency situations are bounced from one agency to another. There is no interagency mechanism for tracking the re-directed calls to ensure that assistance is provided or to record callers who have not been helped. As a result, calls from desperate people in the desert are dropped, and rescue teams never arrive. In interviews, Border Patrol agents reported recording a much smaller number of calls than did sheriff's offices, possibly indicating that many 911 callers who are transferred from the sheriff to Border Patrol are simply dropped – and that people desperate for help in the desert are not able to access emergency services. In a 2015 interview, BORSTAR officers in Tucson sector stated that they responded to 138 callers, while 911 dispatchers in Ajo, Arizona stated that they transferred 681 calls to BORSTAR during the same period – indicating that BORSTAR only picked up 20 percent of the transferred calls. In Pima County, emergency responders estimated that around 70 percent of the 911 calls they refer to BORSTAR do not go through at all.⁵⁴

There are also reports of Border Patrol failure to respond when witnessing injuries from tactical infrastructure. In Arizona, a woman deported to Nogales, Mexico after fracturing her ankles when she fell off the border fence, stated that she was left lying there for hours; though Border Patrol agents had seen her, they did not stop to help.⁵⁵ Those who are rescued by ambulances and taken to the hospital will be stabilized and

then discharged for deportation – in some cases with a permanent disability, and in many cases in spite of inaccessibility of the necessary treatment in their country of origin.⁵⁵

Consistent with U.S. Customs and Border Protection’s primary mission of law enforcement, as a general policy, border crossers who are rescued are often subject to enforcement as a first priority, with medical care as secondary.⁵⁶ Referral to treatment at a medical facility is at the discretion of the Border Patrol agent, who is empowered to detain or deport without further treatment, if such treatment is assessed to be unnecessary, even by non-medical personnel.⁵⁷ In one tragic case in December 2018, a seven-year-old girl apprehended in the desert underwent “medical screening” by agents with no medical training and was determined to be healthy; she died eight hours later, reportedly from severe dehydration.⁵⁸

BORSTAR agents, many of whom are EMTs, represent a small percentage (as low as two percent in some areas) of Border Patrol agents, most of whom do not have any medical training.⁵⁹ A recent Department of Homeland Security statement stated that 1,300 Border Patrol agents are trained as EMTs, out of a total of 19,437 agents.⁶⁰ Nevertheless, it is the agent who decides on the level of treatment a migrant will receive. Statistical analysis of data in 2007 from the U.S. Border Patrol Border Safety Initiative Incident Tracking System found that migrant deaths were not reduced by the Border Safety Initiative, which established BORSTAR.⁶¹ However, the ratios of deaths to rescues is significantly lower for BORSTAR agents. According to 2003 data, the probability of death for migrants responded to by regular Border Patrol agents was 47 percent, compared to seven percent for migrants responded to by BORSTAR agents, even when controlling for other variables, including death type, geographic sector, age, gender, and number of accompanying migrants.⁶²

Rights Violations and Harms Committed by Border Patrol Agents in Hospitals

Violation of Patients’ Right to Privacy

“Border Patrol presence is so pervasive at [the hospital] – they’re profiling in the waiting rooms, they’re roaming the halls, they’re swarming all over that place.”

A human rights lawyer in Tucson, Arizona

For the migrants who are referred to health care facilities, Border Patrol agents often remain in exam rooms while their charges are receiving treatment, violating the patient’s right to privacy regarding their protected health information.⁶³ Doctors must elicit the patient’s history of what occurred during transit, but patients may withhold this important information for fear that such information will be used against them or that they will incriminate themselves, thus compromising the medical encounter and resulting treatment plan.⁶⁴ An attorney in Arizona told PHR, “Border Patrol presence is so pervasive at [hospitals] – they’re profiling in the

waiting rooms, they're roaming the halls, they're swarming all over that place."⁶⁵ Providers in Arizona reported that Border Patrol agents are present in labor and delivery rooms.⁶⁶ Providers also describe the dehumanizing impact of the lack of privacy on patients, from nursing mothers to patients with severe gastrointestinal problems using bedpans while shackled and watched by agents.⁶⁷

Shackling and Medical Harms

“They physically restrain the patients, even in severe medical condition. The guards are there at all times. Sometimes they are in the hallway, and sometimes they are in the room. [There’s] no doctor-patient confidentiality.”

A human rights lawyer in Tucson, Arizona

Agents have the discretion to handcuff or shackle patients while they are receiving care, instead of the treating physician making a decision about whether those restraints will negatively impact their quality of care.⁶⁸ As a result, Border Patrol uses physical restraints, including five-point shackles, even on patients with very severe medical conditions.⁶⁹ One oncologist described how she could not examine a terminally ill, “gaunt” patient with metastatic cancer with only weeks to live because officers would not remove the restraints that ran across the patient’s chest, arms, and feet.⁷⁰ In another case, Border Patrol agents refused to unshackle an HIV-positive patient brought in from the desert. “I couldn’t think of the rationale of chaining someone who is so sick he almost died,” said the attending physician.⁷¹ Hospital staff report feeling intimidated by Border Patrol agents who bring in shackled patients and refuse to leave the room during exams.⁷² Physical restraints can pose health dangers to patients; thus, the current standards of the Joint Commission, the oldest and largest standards-setting and accrediting body in U.S. health care, require that the least restrictive intervention be used at all times.⁷³

Prohibition of Contact with Friends, Family, and Legal Counsel

Patients in Border Patrol custody while in the hospital are also subject to “no-contact” lists while facing expedited removal, without access to family, friends, or legal counsel.⁷⁴ When bringing people to the hospital, Border Patrol agents do not register patients under their real names, making them impossible for lawyers or family members to find.⁷⁵ One physician told PHR, “I gave my patient’s room and phone number to his wife, but when she called, the Border Patrol agents would answer [the phone] and threaten her. So, she wasn’t able to talk to her husband and understand how he was.”⁷⁶ A lawyer described how, after she found a patient by going from room to room, Border Patrol told her that the patient was considered equivalent to someone held at a port of entry and could not speak with counsel.⁷⁷ Although patients are regarded as “in custody” for the purposes of denying family visits and access to counsel, if they are in the hospital, patients can be held beyond the 72-hour limit in CBP’s *National Standards on Transport, Escort, Detention, and Search* handbook.⁷⁸

Rights Violations by Customs Officers at Ports of Entry

Violations of U.S. Asylum Law at Ports of Entry

According to U.S. law, aliens who are physically present or arriving in the United States may apply for asylum if they have a well-founded fear of persecution due to their race, religion, nationality, or membership in a particular social group or political opinion.⁷⁹ The right to seek asylum applies to those who cross the border, with or without prior authorization. Nevertheless, migrants seeking to cross the border through legal ports of entry also face rights violations and health harms at the hands of U.S. authorities. U.S. Customs and Border Protection (CBP) has the legal responsibility to inspect and process individuals presenting at ports of entry who have a credible fear of persecution if they were to return to their country. The stated goal of the “prevention through deterrence” strategy is to ensure that asylum seekers present for regular inspection at official ports of entry. However, the CBP practice of “metering,” or admitting very limited numbers of asylum seekers per day, has resulted in vulnerable groups – including children and pregnant women – being exposed to the elements and to possible exploitation or abuse for weeks or months before being admitted for processing.⁸⁰ The legality of this practice under U.S. law is under litigation, but in order for the right to seek asylum to be meaningful, it must be exercised within a reasonable length of time.⁸¹ Internal documents by U.S. Citizenship and Immigration Services asylum officers also provide evidence about more than 100 cases where CBP personnel intimidated and misled asylum seekers about their right to seek asylum, while failing to adequately ascertain whether they had an asylum claim.⁸²

Abusive Treatment at Ports of Entry Cause Bodily Harm and Serious Health Consequences

There are also credible reports that human rights violations are taking place at U.S. ports of entry in the context of regular border crossing. Documented customs officer conduct shown to endanger life has been met with a dangerous lack of accountability. For example, customs officers at the San Ysidro port of entry near San Diego, California, are recorded on video in 2017 seemingly encouraging a 16-year-old boy to drink liquid methamphetamine from a bottle he was smuggling to prove it was apple juice; he died of an overdose while handcuffed to a gurney.⁸³ The officers were never disciplined, as CBP’s Office of Professional Responsibility “determined that no further action was warranted.”⁸⁴ In another case, border officers beat and Tased a handcuffed man, who suffered a heart attack and stopped breathing while being held face down with an agent kneeling on his back.⁸⁵ One million dollars in damages was awarded to the family, but the agents involved were not disciplined in any way.⁸⁶

Unjustifiable Body Cavity Searches

U.S. Customs officers have conducted invasive and traumatizing body cavity searches without warrants or voluntary consent, in violation of CBP’s *National Standards on Transport, Escort, Detention, and Search* handbook. In many cases, these searches

could not be justified for any law enforcement reason as they did not result in arrest, detention, or deportation, because no contraband was found through the searches. Medical personnel in hospitals have carried out procedures, including pelvic exams, anal and genital probing, X-rays, catheterization, and CT scans at the request of government officers, without a warrant or patient consent.⁸⁷ CBP does not release information about the number of body searches conducted by medical professionals at the request of CBP personnel which did not result in arrest, detention, or deportation.

The Center for Public Integrity has investigated 11 lawsuits that have been filed over body cavity searches since 2011, but emphasizes that these cases are likely to be significantly underreported due to the trauma experienced by the victims.⁸⁸ The involvement of medical personnel can lend a veneer of legitimacy to this violation of CBP guidelines and the right to bodily integrity, potentially further suppressing reporting. In one case reported in the media, a U.S. citizen of Mexican origin who was arrested without a warrant was subjected to a vaginal and rectal search using a speculum, followed by an X-ray and a full-body scan; she reports that the nurses told her to “calm down” and acted as if these invasive procedures were normal.⁸⁹ A journalist following the case filed a FOIA request and was informed that CBP has no information about drug searches not resulting in charges,⁹⁰ even though CBP’s *National Standards* handbook requires that all body cavity searches be documented in “appropriate electronic systems of record.”⁹¹ In another case, a woman was tied to a bed with restraints; medical staff then stripped her naked, removed a tampon from her vagina, administered sedatives using an IV, catheterized her for urine collection, and put her through X-rays and abdominal and pelvic CT scans.⁹² Cases investigated by the Center for Public Integrity have resulted in hefty financial settlements to the victims, which have allowed state agents to avoid incriminating testimony or criminal conviction.⁹³ Strategic litigation in previous cases mandated additional training on searches and Fourth Amendment law for Border Patrol agents and hospital staff. Trainings were conducted on the legal standards for body searches, which require informed consent or a warrant from a judge; however, violations continue to be reported.⁹⁴

Unsafe Medical Discharge through Ports of Entry

International “patient-dumping,” or medical repatriation, is another medical ethical concern raised about the health and survival of immigrants who are deported after seeking emergency medical care, even if continuing care for their condition is not accessible to them in their home country.⁹⁵ The American Medical Association’s Council on Ethical and Judicial Affairs has recommended as a minimum standard for safe patient discharge that all repatriation be voluntary and carried out with informed consent, including information about the medical consequences of the removal.⁹⁶ Health professionals in border communities have described practices which would not meet any minimum standard for safe discharge of patients – for example, patients deported to Mexico from U.S. hospitals with IVs, catheters, and stents in place but without anyone having checked if resources for ongoing care are present in the removal destination.⁹⁷

Afraid to Go to the Hospital: Public Health in the Borderlands

Border Enforcement Limits Access to Hospitals

Border enforcement does not only encompass actions in the immediate vicinity of the border; U.S. Customs and Border Protection (CBP) has authority to operate within 100 miles of the international border.⁹⁸ The increased presence of border and immigration enforcement agents at medical facilities has led to patients missing or cancelling routine appointments in greater numbers, or even refusing to seek medical services altogether.⁹⁹ One health center reported a drastic drop in patient visits – a decrease of 1,000 visits from 2016 to 2017 – as discriminatory routine road stops by agents increased in intensity, including even the stopping and detaining of people with valid visas.¹⁰⁰ A provider from the health center described borderland residents as “essentially imprisoned” in a limited area without access to medical care, which is only available at hospitals past the checkpoints.¹⁰¹ A researcher found that a roadblock in Arizona was well known as a barrier to accessing emergency health care, as ambulances must pass cameras, dogs, and agents at the checkpoint in order to reach the hospitals in Tucson, the nearest location with advanced care.¹⁰² Anecdotally, in a number of interviews, counterparts told Physicians for Human Rights (PHR) that Border Patrol agents were known to wait in hospital parking lots and to racially and ethnically profile people in hospital waiting rooms, leading residents to fear and avoid seeking emergency medical care.¹⁰³

Discrimination Negatively Affects Physical and Mental Health

Public health research has documented widening racial and ethnic health disparities as a result of punitive and discriminatory immigration enforcement practices within the militarized border zone. Discrimination is linked with worsened health and mental health outcomes for immigrants, including symptoms of anxiety, depression, and low self-esteem, while immigration raids and discretionary stops have been documented as causing post-traumatic stress disorder (PTSD) symptoms.¹⁰⁴ Chronic minimization and internalization of these traumas may increase the risk of both physical and mental health conditions, including impaired immune function, inflammation, obesity, and chronic diseases.¹⁰⁵

Anecdotally, health professionals with years of clinical experience in health facilities at the border reported to PHR that stress-related complaints like headaches and pain are exacerbated by patients’ concerns about their immigration status,¹⁰⁶ which are also causing higher levels of depression.¹⁰⁷ In a study in which 90 percent of the respondents were U.S. citizens living in the borderlands, more than 30 percent reported experiencing intense stress due to militarization (“pervasive encounters with immigration officials ... with military-style tactics and weapons”) throughout local institutions and community spaces, including residential and commercial areas.¹⁰⁸ Researchers highlighted the biopsychological significance of elevated stress levels, as harsh immigration policies have been linked with decreased rates of access to health, education, and social services.¹⁰⁹ An October 2018 study shows that deportation and family separation harm both child and adult health, with nearly one in five children in the Rio Grande Valley (regardless of immigration status)

experiencing symptoms of PTSD, compared with one in 20 children in the general population. Adults in the area also experience mental and physical health challenges, as well as difficulty accessing medical care.¹¹⁰

Legal Framework

U.S. Policies Should Protect Patients and Communities

U.S. policies and federal agency guidelines recognize legal obligations to protect all those within U.S. jurisdiction from arbitrary deprivation of life, and to ensure respect for bodily integrity and freedom from ill-treatment. For example, the U.S. Emergency Medical Treatment and Labor Act respects the obligation to protect life by enabling emergency responders to provide evidence-based treatment regardless of insurance or ability to pay, including for undocumented immigrants. The Customs and Border Protection's (CBP) *Use of Force Policy, Guidelines and Procedures Handbook* regulates use of force and requires that all use of force be necessary and proportionate in order to prevent arbitrary deprivation of life. The establishment of BORSTAR, with its search and rescue mandate, affirms the state obligation to preserve and protect life, and to provide lifesaving rescue assistance as a priority. The Sensitive Locations directive, which governs the scope of CBP enforcement in relation to community institutions such as courtrooms and schools, recognizes that hospitals should be safe places to receive treatment. The directive stipulates that immigration enforcement should not take place in hospitals except in the most extreme circumstances, allowing health professionals to treat patients without interference. The CBP's *National Standards on Transport, Escort, Detention, and Search* handbook prohibits body cavity searches without a warrant or voluntary consent.

The Right to Life Must Be Respected at All Times

The U.S. Constitution states that no individual may be deprived of the right to life without due process of law.¹¹¹ The right to life is the paramount right, which must be respected in order to access any other rights.¹¹² All U.S. policies and practices should aim to ensure protection of life, regardless of migration status. Where policies are designed with a foreseeable increased risk of death, fatalities are tolerated and a culture of impunity develops. The overall result will be an increase in preventable deaths, tantamount to assisting in arbitrary deprivation of life. At the border, the U.S. government must uphold mandatory obligations to relieve imminent danger to lives and safety as a first priority.¹¹³ The legal obligation to save lives must be implemented through evidence-based policy decisions, refining practices based on rigorous evaluation.¹¹⁴ The UN Special Rapporteur on the human rights of migrants noted with grave concern that intensified border control has resulted in a cascade of side-effects that increase dangers to migrants, including death.¹¹⁵

Use of Force Must Be Necessary, Proportionate, and Non-discriminatory

The U.S. obligation to respect the right to life includes the duty to ensure that all use of force is strictly necessary, proportionate to its aim, and implemented in a non-discriminatory manner. It also requires that the government exercise due diligence to prevent foreseeable and preventable deaths through its policies and the acts and omissions of state agents. Force may not be employed in a discriminatory manner. The state is obligated to properly investigate all unlawful deaths in order to ensure accountability, provide remedies to victims, and to end or reform any policies which directly or indirectly cause violations of the right to life.¹¹⁶ Due diligence doctrine requires an assessment of: 1) how much the state knew or should have known about the risk of harm; 2) the objective risk or likelihood of harm; and 3) the seriousness of the harm.¹¹⁷ Indirect use of force must also respect legal limits. Policies and practices mentioned throughout this report predictably increase the risks of health harms and death across the migration cycle.¹¹⁸ For example, policies which push asylum seekers back when they have expressed that they are fleeing persecution, which intentionally funnel migrants toward natural hazards such as the desert, and which purposely expand the use of manmade hazards such as tactical infrastructure are documented as resulting in health harms.¹¹⁹ Criminal prosecution of those offering lifesaving assistance impedes civil society actors from treating injuries and providing lifesaving assistance, such as water, at the border, and increases the risk that migrants will not survive the journey.

Non-discriminatory Access to Emergency Health Care Is a U.S. Obligation

The right to non-discriminatory access to emergency health care is closely linked with the right to life. Emergency health care must be provided without discrimination. Government bodies must respect the constitutional right to equal protection and may not deny or diminish protective services to “certain disfavored minorities,” including those believed to be unauthorized immigrants.¹²⁰ The state obligation to respect the right to equal protection and non-discrimination includes the obligation not to interfere arbitrarily in the provision of medical care and to eliminate systemic discrimination in health care systems. Under U.S. domestic law, the right to emergency medical care regardless of ability to pay or immigration status is well established.¹²¹ In these laws, emergencies are defined as situations where the absence of immediate medical attention could reasonably be expected to place the health of the individual in serious jeopardy.¹²² International human rights mechanisms also enjoin states to ensure that lifesaving emergency medical care is provided without discrimination, including for asylum seekers and other migrants.¹²³

Hospitals Must Not Be Used as De Facto Detention Centers

“You think of a hospital as a place of healing...and there are border patrol officers interfering with that place of healing.”

Claire Lamneck, medical student at the University of Arizona and border activist

The delivery of medical care must respect medical ethics and human rights standards, protections which apply also to non-citizens. Hospitals should not be treated as de facto detention centers, lacking in due process protections. According to the existing Immigration and Customs Enforcement (ICE) and CBP Sensitive Locations directive, hospitals should be respected as protected locations where patient medical needs are paramount.¹²⁴ The constitutional right to privacy and non-interference with family and private life requires that medical patients' confidential health information be protected, that health care providers have autonomy to provide evidence-based treatment in the patients' best interest, and that families know of the whereabouts of their family members and are able to contact them in the hospital during their treatment. Due process protections apply also to non-citizens under U.S. law. “No contact” lists for hospital patients in Border Patrol custody call into question meaningful access to due process, as those affected will not have access to legal counsel. Depriving patients of contact with family and friends, who may not know the whereabouts of the individual, may facilitate temporary (or even permanent) disappearances; disappearances, no matter how temporary, should be strenuously avoided.¹²⁵ Codifying the Sensitive Locations policy into the Immigration and Nationality Act would help to end these practices and protect the right to non-discriminatory access to emergency medical services.

Policy Recommendations

To the U.S. Congress:

- Ensure non-discriminatory access to emergency medical services through adoption of legislation that codifies the Sensitive Locations policy into the Immigration and Nationality Act;
- Ensure that access to lifesaving medical and other humanitarian assistance is safeguarded by explicitly protecting from prosecution those who offer medical or humanitarian services to migrants;
- Separate search and rescue from law enforcement by clarifying the respective mandates of Border Patrol and local search and rescue efforts, to ensure that medical personnel and activities are protected from pressures to prioritize immigration policy enforcement over medical care, and to ensure that those who are rescued have access to medical care;
- Review U.S. Customs and Border Protection authority under the “100-mile rule” to determine how constitutional protections can be preserved in and around medical facilities while implementing border enforcement activities.

To the Department of Homeland Security and U.S. Customs and Border Protection (CBP):

- Rigorously evaluate border enforcement practices for negative impact on the right to life, including through ongoing consultations with independent medical professionals to evaluate health consequences of existing policies and practices and during development of new policies and guidelines;
- Publicly clarify CBP’s existing Sensitive Locations policy, which prohibits enforcement actions that impede first responders from delivering lifesaving treatment;
- Train agents to effectively avoid any excessive use of force and to respect medical ethics and medical professional opinions regarding the medical needs of patients impacted by enforcement actions at all times, including updating the CBP *Use of Force Policy, Guidelines and Procedures Handbook* and improving training for agents;
- Fully investigate allegations of harm perpetrated by agents, sanction agents who violate guidelines, and make the results of those investigations public;
- Abide by the standards in the CBP *National Standards on Transport, Escort, Detention, and Search* handbook that strip searches, X-ray searches, body cavity searches, and monitored bowel movements must be recorded in an electronic system of record, including the reason for the search and who authorized the search;¹²⁶
- Enforce the standards in the CBP *National Standards on Transport, Escort, Detention, and Search* handbook that body cavity searches are conducted “only under the most exceptional circumstances,”¹²⁷ by medical practitioners in a medical facility, with either the individual’s consent or a search warrant from a judge;
- Foster closer collaboration with community groups, including those providing medical assistance to migrants.

What Can Health Professionals Do?

- Academic institutions can support research on the overall impact of immigration enforcement actions on health and on the health care system, individual health, and population health in border regions;
- U.S. health professional associations can publish policy and position statements, as well as medical ethics standards related to immigration enforcement activities and their impact on migrant populations and the health care workforce;
- Hospitals can develop internal policies and protocols to protect patient rights regardless of immigration status and to uphold U.S. law, including by protecting confidential patient information and patients' right to informed consent, and by consistently opposing arbitrary interference in patient care;
- Hospitals and other health facilities can educate staff on immigration issues, applicable laws, and the Immigration and Customs Enforcement (ICE) and CBP Sensitive Locations policy and prepare staff for interaction with border and immigration enforcement;
- Health professional organizations, state and institutional ethics boards should enact policies protecting doctors from reprisal in cases where they act in accordance with medical ethics and U.S. law to protect patient privacy and bodily integrity and to prioritize patient health during border enforcement activities;
- Health professionals can inform themselves about patients' rights in order to actively ensure protection of human rights in their clinical setting, including by reporting suspected violations by ICE or CBP to ICE Enforcement and Removal Operations, and speaking out through op-eds and social media to advocate for border and immigration management which respects health and human rights.

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