1-1-2015

Pathogenic Policy: Health-Related Consequences of Immigrant Policing in Atlanta, GA

Nolan Sean Kline
University of South Florida, nskline@mail.usf.edu

Follow this and additional works at: http://scholarcommons.usf.edu/etd
Part of the Public Health Commons, and the Social and Cultural Anthropology Commons

Scholar Commons Citation
Kline, Nolan Sean, "Pathogenic Policy: Health-Related Consequences of Immigrant Policing in Atlanta, GA" (2015). Graduate Theses and Dissertations.
http://scholarcommons.usf.edu/etd/5864

This Dissertation is brought to you for free and open access by the Graduate School at Scholar Commons. It has been accepted for inclusion in Graduate Theses and Dissertations by an authorized administrator of Scholar Commons. For more information, please contact scholarcommons@usf.edu.
Pathogenic Policy: Health-Related Consequences of Immigrant Policing in Atlanta, GA

by

Nolan Kline

A dissertation submitted in partial fulfillment of the requirements of the degree of Doctor of Philosophy Applied Anthropology with a concentration in biocultural medical anthropology
Department of Anthropology
College of Arts and Sciences

and

Master of Public Health
Department of Community and Family Health
College of Public Health
University of South Florida

Co-Major Professor: Heide Castañeda, Ph.D., M.P.H.
Co-Major Professor: Angela Stuesse, Ph.D.
Mathew Coleman, Ph.D.
Ellen Daley, Ph.D., M.P.H.
Daniel Lende, Ph.D.

Date of Approval:
March 12, 2015

Keywords: Biopolitics, Citizenship, Secure Communities, 287(g), Engaged Anthropology.

Copyright © 2015, Nolan Kline
ACKNOWLEDGMENTS

Writing this dissertation would not have been possible without the support and mentorship from numerous people. I am grateful to everyone who played a role in my success, and I thank my committee members for their feedback and guidance throughout this process. I am especially appreciative of Heide Castañeda for providing continuous support and mentorship since I arrived at USF in 2008, and for largely shaping me into the anthropologist I am now. I am also thankful to Angela Stuesse, for inviting me to work on immigrant policing in Atlanta and helping me articulate my activist sentiments into the fieldwork that resulted in this dissertation. Thank you to Ellen Daley for encouragement, countless orange slices and pieces of chocolate, and providing me with opportunities to expand my interests and abilities. I am also appreciative of Mathew Coleman for directing me to scholarship that expanded my theoretical interests and provided the underpinnings of this and future work. Similarly, thank you to Daniel Lende for encouraging me to expand my theoretical horizons and venture beyond my academic comfort zone. Not everyone is as fortunate as I have been to have such a fantastic committee, all of whom guided me and played a role in my success and growth as a scholar.

In addition to my committee members, I appreciate my undergraduate mentor, Rachel Newcomb, for inspiring my interest in anthropology and encouraging me to consider graduate school and academic careers. I am grateful to my husband David, for proofreading every chapter, always being the person with whom I talk through ideas, and being generally thoughtful and understanding throughout this entire endeavor. My mother, Irma, made several sacrifices that allowed me to advance to where I am now, and I appreciate her support. I am thankful for all of
the connections I made in Atlanta, especially the GLAHRiadores, who inspired me to not only fight for the rights of others, but to fight for my own rights, too. There were also many people who provided encouragement during my writing process, including Laura Merrell, Erika Thompson, and Alison Cantor, whose certainty in my abilities kept me motivated.

Lastly, I would like to acknowledge the National Science Foundation and University of South Florida Proposal Enhancement Grant for providing financial support that made this research possible. Thank you to Angela Stuesse and Mathew Coleman for securing this funding, without which I would not have been able to do the research or make the connections that have had a meaningful impact on me.
TABLE OF CONTENTS

List of Tables ................................................................................................................. v

List of Figures ................................................................................................................... vi

Abstract ............................................................................................................................ viii

Chapter One: Introduction: Multilayered Immigrant Policing in Atlanta, Georgia .......... 1
  Introduction ....................................................................................................................... 1
  Why Atlanta? ................................................................................................................... 5
  Immigrant Rights Organizations .................................................................................... 11
  Chapter Summaries ........................................................................................................ 13

Chapter Two: Undocumented Immigrants’ Exclusion from Health Care in the United States and Georgia as a Continuation of Historic Forms of Exclusion ........................................... 17
  Introduction ..................................................................................................................... 17
  Federal Policies of Exclusion ......................................................................................... 19
    Background: Race and Immigrant Exclusion .............................................................. 19
    Relegating Undocumented Immigrants to the Emergency Room .............................. 24
    Immigration and Health in Neoliberal Reforms .......................................................... 27
    Immigration and Health Care Reform ......................................................................... 31
    Racialized Criminality of Undocumented Immigrants ............................................... 33
    Counterarguments ...................................................................................................... 39
  Immigration Legislation in Georgia .............................................................................. 41
  Conclusion ....................................................................................................................... 47

Chapter Three: The Biopolitics of Immigrant Policing: Governing Through Fear to Produce an Ideal Neoliberal Citizen ....................................................................................... 49
  Introduction ..................................................................................................................... 49
  Power ............................................................................................................................... 50
  Biopower ......................................................................................................................... 53
  Biopolitics and Vehicles of Social Division ..................................................................... 61
    Racialization of Nationality ......................................................................................... 68
    Deservingness as a Form of Racism ............................................................................. 70
  Citizenship ....................................................................................................................... 73
  Using Fear to Produce the Ideal Neoliberal Citizen ....................................................... 77
    Reinforcing Racialized Notions of Immigrants’ Illegality ........................................... 81
  Conclusion ....................................................................................................................... 83

Chapter Four: Methods and Methodological Framework .............................................. 85
## Chapter Seven: Family-Related Impacts of Immigrant Policing

**Introduction** .................................................................................................................. 206  
**Family-Related Impacts of Immigration Laws and Family Violence** ....................... 211  
**Immigrant Children and Immigrant Policing** .......................................................... 211  
**Intimate Partner Violence and Immigrants in the United States** .......................... 214

---

### Chapter Five: Understanding Policy Makers’ Perspectives in Georgia’s Immigration Laws

**Introduction** .................................................................................................................. 126  
**Experiences at the Capitol and Interviews with State Legislators** ......................... 130  
**Tracing Policies to Anti-Immigrant Activists** ............................................................ 139  
**The IERB** ...................................................................................................................... 142  
  **Bringing Complaints Against Agencies through HB 87** ......................................... 145  
  **Responding to King’s Accusations** ........................................................................... 149  
  **Non-Compliance Accusations Continue to be Heard at the IERB** ...................... 151  
  **HB 125 Passing** ....................................................................................................... 155  
**Discussion** .................................................................................................................. 158  
**Conclusion** ................................................................................................................ 164

---

### Chapter Six: “Vivimos Aquí con Miedo:” Fear and Health-Related Impacts of Immigrant Policing on Undocumented Immigrants in Atlanta

**Introduction** .................................................................................................................. 165  
**Governing Through Crime, Local Enforcement, Fear, and Mobility** .................... 172  
**Experiencing Fear and Trauma: Reactions to Immigration Policing** ................... 176  
**Finding New Avenues of Care** .................................................................................. 179  
**Changing Health Behaviors** .................................................................................... 188  
**Discussion** ................................................................................................................ 191  
  **Changing Mobility** ................................................................................................. 192  
  **Fear-Based Governance** ......................................................................................... 193  
  **“Black Market Medicine:” Parallel Medical Care in Atlanta** ................................. 198  
  **Feeling Racial Discrimination in the Clinic** ........................................................... 200  
  **Pathogenic Policing** ............................................................................................... 202  
**Conclusion: Belied Care** ............................................................................................ 204

---

### Chapter Seven: Family-Related Impacts of Immigrant Policing

**Introduction** .................................................................................................................. 206  
**Family-Related Impacts of Immigration Laws and Family Violence** ....................... 211  
**Immigrant Children and Immigrant Policing** .......................................................... 211  
**Intimate Partner Violence and Immigrants in the United States** .......................... 214

---

### Table of Contents

- Introduction ................................................................. 85
- Policy as an Ethnographic Object ........................................... 86
- Engaged Anthropology ......................................................... 93
  - Engaged Anthropology and Health-Related Research ......................... 99
- Locating Resistance to Power Processes ........................................... 100
- Ethical Considerations of Engaged Anthropology ................................. 103
- Studying Networks and Connections: The Case for Multi-Sited Ethnography  ........ 105
- Sources of Data Collection ..................................................... 113
  - Interview Recruitment and Eligibility ....................................................... 115
  - Archival Media Analysis ............................................................................ 116
  - Interview and Field Note Data analysis ...................................................... 117
  - Challenges ..................................................................................................... 117
- Applied Contributions ................................................................................. 122

---

*Note: The table continues with additional entries for each chapter.*
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discussion</td>
<td>315</td>
</tr>
<tr>
<td>Subsidizing Private Care and Producing Patient Citizens</td>
<td>315</td>
</tr>
<tr>
<td>Eviscerating the Safety Net for Undocumented Immigrants and Indigent Patients</td>
<td>317</td>
</tr>
<tr>
<td>Immigrant Policing and Efforts to Increase Attrition</td>
<td>318</td>
</tr>
<tr>
<td>Conclusion</td>
<td>319</td>
</tr>
<tr>
<td>Chapter Ten: Life, Death, And “Dialyzing For Dollars:” The Biopolitics of End-Stage Renal Disease</td>
<td>321</td>
</tr>
<tr>
<td>Introduction</td>
<td>321</td>
</tr>
<tr>
<td>Finding ESRD as a Research Topic</td>
<td>322</td>
</tr>
<tr>
<td>End-Stage Renal Disease and Treatment</td>
<td>323</td>
</tr>
<tr>
<td>Dialysis and Chronic Kidney Disease Policy in the United States</td>
<td>325</td>
</tr>
<tr>
<td>Dialysis and Georgia’s Changing Emergency Medicaid Policies</td>
<td>327</td>
</tr>
<tr>
<td>Grady Treatment and Closing the Outpatient Dialysis Center</td>
<td>329</td>
</tr>
<tr>
<td>“When You’re Sicker, Come Back:” The Emergency Room as a Last Resort</td>
<td>333</td>
</tr>
<tr>
<td>Discussion: Managing Precarious Life and Health Policy as Immigrant Policing</td>
<td>336</td>
</tr>
<tr>
<td>Conclusion: Being Stuck and Barely Alive</td>
<td>340</td>
</tr>
<tr>
<td>Conclusion</td>
<td>341</td>
</tr>
<tr>
<td>Introduction</td>
<td>341</td>
</tr>
<tr>
<td>Fear, Neoliberal Citizens, and Hypercitizenship</td>
<td>343</td>
</tr>
<tr>
<td>Race, Policing, Detention, and Citizenship</td>
<td>346</td>
</tr>
<tr>
<td>Pathogenic Policing as a Policy Syndemic</td>
<td>348</td>
</tr>
<tr>
<td>Reflection on Health-Related Engaged Research</td>
<td>349</td>
</tr>
<tr>
<td>Recommendations for Policy Directions</td>
<td>353</td>
</tr>
<tr>
<td>References</td>
<td>357</td>
</tr>
</tbody>
</table>
LIST OF TABLES

Table 1: Interviews conducted and for which project the interviews were conducted. .............. 114
LIST OF FIGURES

Figure 1: With GLAHRiadores outside of Stewart Detention Center, a facility where immigrants are detained until they are deported. ................................................................. 70

Figure 2: Holding a sign during a large public demonstration for immigrant rights outside of the Georgia Capitol. ........................................................................................................ 94

Figure 3: Hugging a GLAHRiador during a Christmas Party where I received a thank you from GLAHR leaders for participating in events.................................................. 100

Figure 4: Holding a banner as part of a protest against Stewart Detention Center in Lumpkin, GA.................................................................................................................. 101

Figure 5: Bronfenbrenner’s Ecological Systems Model............................................................... 111

Figure 6: The Social Ecological Model of Health ........................................................................ 113

Figure 7: GLAHRte Installation at Georgia State University. GLAHRiadores and I created birds and the sun and hung them on a wall as part of an undocumented immigrant art installation. .............................................................. 121

Figure 8: At one of the immigrant rights marches I assisted GLAHR with organizing......... 124

Figure 9: Assisting a woman with legal documents. .................................................................. 128

Figure 10: Inside Georgia's Capitol. .......................................................................................... 131

Figure 11: DA King staring at the photographer, Roberto Gutierrez, during an IERB Meeting......................................................................................................................... 145

Figure 12: An example of a Latino clinic no longer in operation............................................. 185

Figure 13: A market with a vehicle to transport customers so they do not have to drive........ 193

Figure 14: The start of the "Keeping Families Together" bus tour............................................. 220

Figure 15: Playing George W. Bush in a teatro popular............................................................. 221

Figure 16: Rehearsing the scene in the first teatro popular in which a young girl's mother is arrested while driving her to school.................................................. 222
Figure 17: The cast of the second *teatro popular* featuring the story of Maria......................... 223

Figure 18: Playing Santa's Elf during a GLAHR letter-writing action.............................................. 229

Figure 19: Holding family reunification signs outside a legislator's office during the
"Keeping Families Together" bus tour................................................................. 254

Figure 20: Grady Memorial Hospital seen from driving around "Grady Curve," a portion of
I-75 that borders the hospital................................................................. 289

Figure 21: The main entrance to Grady Memorial Hospital................................................................. 299

Figure 22: A play on Grady's slogan, "Atlanta can't live without Grady." During Hospital
week, this banner is placed outside a parking garage and reads "Grady can't live
without you."................................................................. 302

Figure 23: Outside an Atlanta courthouse after a political demonstration......................... 356
ABSTRACT

Multilayered immigration enforcement regimes comprising state and federal statutes and local police practices demand research on their social and health-related consequences. This dissertation explores the multiple impacts of immigrant policing: sets of laws and police activities that make undocumented immigrants more visible to authorities and increase their risk of deportation. Examining immigrant policing through a multi-sited framework and drawing from principles of engaged anthropology, findings from this dissertation suggest how immigrant policing impacts undocumented immigrants’ overall wellbeing, health providers’ professional practice, and reveals troubles with safety net medical care. Interviews and participant observation experiences suggest how immigrant policing perpetuates a type of fear-based governance that shapes where undocumented immigrants seek health services, the types of services they seek, and exacerbates intimate partner violence. Moreover, research findings point to how immigrant rights organizations and health providers resist biopolitical efforts to control undocumented immigrants, especially in situations of life or death when institutional authority may limit how undocumented immigrants receive life-sustaining care. Findings from this research respond to calls to examine state immigration laws and their impact on health, and demonstrate the lived experiences of undocumented immigrants in Atlanta who confront an increasingly hostile immigration system.
CHAPTER ONE

INTRODUCTION: MULTILAYERED IMMIGRANT POLICING
IN ATLANTA, GEORGIA

“After 287(g) and that big anti-immigration law [HB 87], undocumented immigrants were afraid to come to us for services, so we have to go to them.”—A staff member of a sexual and reproductive health organization.

“Republicans are doing whatever they can to make Georgia hostile to immigrants.” – Georgia State Legislator

Introduction

At a weekly Monday night meeting at the Georgia Latino Alliance for Human Rights (GLAHR), Inés, the leader, reminded everyone of how important it was to drive carefully. She had just taken a phone call on the GLAHR hotline in which a woman named Esme called to ask for help regarding her husband who had been arrested for driving without a license. He was stopped for having a broken taillight that Esme swore she had checked and worked fine the week before county police apprehended him. Now in a county jail, Esme feared her husband would be deported back to Mexico, and she asked Inés for help figuring out what would happen to him. Inés informed her that the Immigration and Customs Enforcement (ICE) had forty-eight hours to put a detainer on him, and gave Esme the phone number of a lawyer to consult. Shortly after hanging up the phone, Inés walked out of her office and went to the room full of GLAHR members, collectively known as GLAHRIadores, a linguistic play on gladiators (gladiadores), where she discussed Esme’s situation.
“Compañeros, we all know how important it is to drive carefully, sí?” Inés asked, sparking a conversation on a frequently discussed topic. She and other GLAHRiadores reiterated strategies for avoiding police scrutiny, such as ensuring tail and brake lights worked, using turns signals, driving under the speed limit, and always wearing seatbelts.

“Sí, es muy importante,” Inés summarized. “They [the police] will stop you; you have to make sure everything is functioning properly on your car, always wear a seatbelt, and drive under the speed limit.” The conversation at GLAHR that night summarized what many immigrants in Atlanta identified as a pressing problem threatening their communities: policing and arrests made for traffic violations that could result in deportation and demanded political and social action. For many undocumented Latino immigrants I met in Atlanta, police activity fit into a broader context of anti-immigrant sentiment codified in state laws and federal statutes that operated locally.

In this dissertation, I examine the multiple impacts of immigrant policing in Atlanta, Georgia. Immigrant policing comprises legislation, policies, and police practices that render undocumented immigrants visible to authorities for arrest and potential deportation. These activities ultimately shape undocumented immigrants’ agency and manifest in ways such as limiting mobility and changing daily habits. Examining the numerous impacts of immigrant policing that extend beyond undocumented immigrants, this dissertation examines the biopolitical reach of immigration policies and police practices, exploring pathways of policy as a form of governmental power that pervades multiple social spaces, specifically focusing on health-related consequences. As such, I examine immigrant policing as a form of health policy. Adding to a definition offered by Singer and Castro, I conceptualize policy as “official [and in some circumstances unofficial] guidelines implemented by a social institution intended to set a
direction for action,” and health policy as including, among other things “policy with another purpose but nonetheless having a direct impact on health” (Singer and Castro 2004: xi). Immigration enforcement efforts are such policies as they are driven by objectives unrelated to health but have health-related impacts. When combined with a multi-sited perspective, exploring immigrant policing as health policy reveals how immigration regimes shape individuals’ health directly and indirectly, can affect the entire health system in hidden ways, and speaks to broader systems of health-related inequality.

Immigration policy deserves critical attention as new forms of enforcement have emerged, resulting in “layered” governmental responses that have created multiple forms of immigration enforcement and threats of discovery, or “multiple ‘migras,’” or “poli-migra” (Menjívar 2014: 5). The current “poli-migra,” an amalgam of federal statutes, state laws, local ordinances, and police activities targeting undocumented immigrants, disproportionately impacts Latinos regardless of status and serves as a “force multiplier” of immigration enforcement (Menjívar 2014: 5). Layered immigration enforcement amplifies the effects of efforts to move borders inwardly and locally (Leerkes et al. 2012), shaping undocumented immigrants’ social disadvantages that impact long term and short term opportunities (Menjívar 2014), including access to health services and overall wellbeing (Berk 2000; Cleaveland and Ihara 2012). This dissertation describes some of the short-term health impacts and suggests some broader long-term impacts of immigrant policing in Atlanta. In focusing on health-related impacts of policing, I specifically explore how localized immigration regimes alter undocumented immigrants’ health behaviors and family relationships, implicate health providers in policing efforts, and impact the entire medical safety net. Beyond accounting for how immigrant policing shapes health among undocumented Latinos, however, this dissertation is fundamentally concerned with exercises of
power that take shape as immigrant policing and affect undocumented Latino immigrants and their communities in a variety of ways.

To trace the broad impacts of immigrant policing as a form of power, I chose multi-sited ethnography as a methodological framework for considering interconnected but potentially dispersed outcomes of an increasingly harsh immigration regime. Borrowing from a health sciences model that conceptualizes how to conduct research at different social levels, I considered how different groups of individuals may have played a role in supporting, opposing, or were directly impacted by immigrant policing. This perspective led me to design a recruitment strategy that included participants from diverse social positions, such as policy makers (either proponents or opponents to immigrant policing efforts), health providers (who were targeted in some immigrant policing objectives and play a role in providing undocumented immigrants’ care), immigrant rights organization leaders (whose positions shape actions and messages responding to immigrant policing objectives), and undocumented immigrants (who are perhaps most dramatically impacted by immigrant policing). As part of a multi-sited approach, I conducted an archival media analysis to understand the overarching rhetoric shaping public discourse on immigration to Atlanta, immigration statutes, and immigration related police efforts.

The multi-sitedness of this project allowed me to keep some forms of data in conversation with others. For example, providers who spoke about patients no longer seeking services due to immigrant policing helped me refine questions to undocumented immigrants about where they sought care, and comments from undocumented patients helped shape questions I posed to providers. Similarly, archival media data helped shape research questions among policy makers, health providers, immigrants, and immigrant rights activists. A multi-sited approach in conducting this research therefore allowed for continuously refining interview
questions and frequent interviewee fact checking. These benefits were weighed with drawbacks, however, as I discuss in chapter three.

**Why Atlanta?**

As a relatively new destination for Latino immigrants and a site of layered immigration enforcement efforts comprising state laws and federally designed local programs, Atlanta was the ideal location for this research. Although immigration concerns have chiefly been a matter of federal oversight, laws are becoming more commonly passed in state legislatures (Lopes 2014), including in Georgia. While some state immigration laws have increased immigrants’ access to social services such as drivers licenses and in-state tuition for undocumented college students (Abrego 2008; Marrow 2012), others have focused on legislating exclusions (Menjívar 2014; Walker and Leitner 2011). Menjívar (2014) notes this is particularly true in new destinations, and especially in southern states (Leerkes et al. 2012) like Georgia. Georgia has passed several state laws limiting undocumented immigrants’ access to social services and followed Arizona in passing a law similar to SB 1070, one of the most publicized recent laws touted as the “toughest immigration law in the country” when it passed (Campbell 2011: 1). Like SB 1070, Georgia’s version, HB 87, adopted immigration enforcement tactics that use local law officers to assess legal status.

Georgia’s immigration laws like HB 87 respond to a new and fast growing immigration population compared to other major metropolitan areas. The Latino population in Georgia has more than doubled since the year 2000, reaching 853,689 in 2010 (U.S. Census Bureau 2010b), and with approximately 64% (547,400) living in metropolitan Atlanta (U.S. Census Bureau 2010a). Although Latino immigration to the state has been associated with agricultural work

---

1 Approximately 440,000 undocumented immigrants live in Atlanta, but specific numbers of
since the 1940s (Walcott and Murphy 2006), immigration to the Atlanta area rose during the 1970s and 1980s fueled by poultry, textile, and construction industries (Winders 2005; Yarbrough 2010). Throughout the 1990s, Atlanta experienced significant economic growth driven by construction, finance, transportation, and utility industries (Odem 2008) that further increased Latino immigration, especially from Mexico as Mexico’s oil-related economic boom ended and there was little job growth in other recipient states such as California (Walcott and Murphy 2006). As the Latino population in Atlanta grew, along with an increasing refugee and Asian immigrant population, Atlanta became home to the largest immigrant population and largest Latino population in the US South\(^2\) (Yarbrough 2010).

Furthermore, the large number of Mexicans arriving to Atlanta in the 1990s was partly due to a need for construction laborers to ensure a timely beginning of the 1996 Summer Olympic Games (Associated Press 2010; Bess 2008; Grillo 2010; Olsson 2014). Prior to the opening of the Olympics, city and state officials experienced a labor shortage and feared construction projects would not be completed on time. Concerned about international embarrassment, Georgia officials met with Mexican governmental representatives and requested an intervention. As one of the former Mexican officials I met while in Atlanta explained:

> They asked us to get workers from Mexico to come and help with construction. They were behind schedule and nothing was going to be completed in time, so they said “just get us workers and we’ll sort out the immigration stuff later.” So we agreed to spread the word, and all over Mexico you started seeing billboards pop up that said “Georgia is hiring,” and things like that. And of course they never fixed the immigration stuff, like they said they would.

undocumented Latinos are not readily available. For more information see:
\(^2\) Outside of Florida
\(^3\) There are a number of local parallels between Arizona and Georgia. In addition to Governor
As this former Mexican government official suggested, the construction sector provided a large number of jobs for Atlanta’s Latino population; in 2000, Latinos accounted for approximately 45% of the construction workforce the area’s counties (Odem 2008). Upon completing Olympics-related projects, immigrants continued to work in construction and participated in Atlanta’s housing boom. The economic downturn of the 2000s, however, saw the crash of the housing market and accompanying decline in construction projects.

The national economic crisis and construction halt in Atlanta fueled nativist sentiment in the metropolitan area. Policymakers interviewed for this dissertation largely explained the economic downturn as the impetus for anti-immigrant laws (as I explain in chapter five) such as SB 529 (2006), HB 2 (2008), and HB 87 (2011). When SB 529 passed, it was the nation’s most aggressive anti-undocumented immigrant legislation, barring adults who could not prove their legal status from any tax-supported benefit and requiring employers receiving state funds to ensure the legal status of their workers (Browne and Odem 2012). SB 529 also required police officers to assess and report to federal authorities the legal status of anyone arrested for driving under the influence of alcohol or a felony (Browne and Odem 2012). Following SB 529, in 2009, the Georgia legislature passed HB 2, which required government agencies to use the federal Systematic Alien Verification for Entitlements (SAVE) system in verifying eligibility for public benefits (Fiscella et al. 2002). The SAVE requirements of HB 2 suggested that immigrants were allegedly abusing public entitlement programs, and combined with policing initiatives written into SB 529, served as the harbinger for Georgia’s most notorious immigration law, HB 87.
In 2011, Georgia Governor Nathan Deal fulfilled a campaign promise of enacting an “Arizona-style” immigration law by signing the Illegal Immigration Reform and Enforcement Act of 2011, more commonly referred to as HB 87. Building upon previous Georgia laws and duplicating key features of Arizona’s SB 1070, HB 87 requires immigrants to carry proof of legal status at all times and compels police officers to stop anyone suspected of being undocumented. The law extends requirements in SB 529 for employers receiving public funds to verify employees’ legal status to private employers, and allows the public to sue state officials who did not enforce laws related to undocumented immigrants (Browne and Odem 2012). It also created the Immigration Enforcement and Review Board (IERB), a committee to ensure compliance with the law and hear public complaints. Further broadening efforts to control undocumented immigrants, HB 87 also criminalized any assistance to undocumented immigrants, potentially implicating taxi drivers, charitable organization leaders, and others who provide various types of aid or services. The provisions surrounding assistance and transportation also prohibited health care professionals from providing any type of publicly-financed, non-emergency health service, effectively criminalizing some health care providers’ professional actions and extending efforts to control undocumented immigrants into medical realms by making medical personnel agents of documentation status surveillance. The Eleventh Circuit Court of Appeals eventually overturned the provisions regarding assistance, but the rest of the law remains in place.

In addition to HB 87 and its progenitors, the Georgia legislature has proposed to ban undocumented youth participating in the Deferred Action for Childhood Arrivals program from

---

3 There are a number of local parallels between Arizona and Georgia. In addition to Governor Nathan Deal campaigning on an Arizona-style immigration law, Cobb County and Gwinnett County Sheriffs Neil Warren and Butch Conway compare themselves and are compared to Maricopa County Joe Arpaio in local media and among activist groups.
obtaining drivers licenses (Foley 2014), and the Georgia Board of Regents, in response to pressures for the legislature, banned undocumented students from attending Georgia’s flagship universities (Brown 2010). Furthermore, during my fieldwork, Georgia legislators proposed two more immigration laws: SB 160 and HB 125, both of which threatened undocumented immigrants’ abilities to open bank accounts, rent apartments, or apply for utilities, as I describe in chapter five.

State laws and education policies, however, are only one portion of the multilayered immigrant-policing regime operating in Georgia. Adding to Georgia’s state laws are federal immigration statutes that operate on local levels: Section 287(g) of the Immigration and Nationality Act and Secure Communities. Section 287(g) allows for state and local law enforcement agencies to act as immigration enforcement officers through agreements with the Department of Homeland Security and the ICE (Shahshahani 2009). As described in greater detail in chapter three, 287(g) agreements allow for simple arrests, such as traffic violations, to become potential triggers for deportation. Similarly, Secure Communities shares arrestee fingerprints obtained in local jurisdictions with federal immigration authorities to assess immigration status. In Georgia, four counties participate in 287(g) (Cobb, Gwinnett, Hall, and Whitfield), all of which are in the Atlanta metropolitan area, and all jurisdictions in the US participated in the Secure Communities program until its recently announced cessation (Johnson 2014). The effects of both programs are a localized immigration enforcement regime whereby

---

4 As I explain in the following chapter, there are three models for 287(g): the jailhouse, task force, and hybrid models. The jailhouse model allows officers to inquire about the legal status of immigrants in their custody, while the task force model allows officers to inquire about immigrants’ legal status while working in the field. As Capps, Rosenblum, Rodriguez, and Chishti (2011: 15) note, this authority gives officers the ability to arrest for immigration violations and issue search warrants. The hybrid model combines the two approaches and allows the jailhouse and task force models to exist concurrently.

5 See the full list of jurisdictions with 287(g) agreements at: http://www.ice.gov/factsheets/287g
the threat of deportation becomes strongly associated with automobile traffic and mobility (Coleman and Kocher 2011; Stuesse and Coleman 2014).

Routine traffic enforcement is a key form of immigrant policing as it renders undocumented immigrants visible to authorities for potential deportation in contexts like Atlanta. During my fieldwork I heard countless stories of immigrants stopped for an ostensibly broken taillight, malfunctioning brake light, or driving with excessive speed leading to arrest and an order for deportation. Such was the story of a woman I met, Carla, whose husband had been arrested for driving without a license after being stopped for a broken tail light. His arrest led to his deportation and Carla was left to care for her two children alone. In addition to routine traffic violations, police practices further involved setting up checkpoints for checking seatbelt compliance or inspection for driving while intoxicated. In Atlanta, reports of checkpoints were common outside of Latino neighborhoods, apartment complexes, and business centers, and by early 2013 the commonality of checkpoints gave rise to the popularity of an anonymous text message service, PaseLaVoz (pass it on), to notify users of potential checkpoints. Police practices are thus the highly discretionary acts associated with stopping, detaining, and arresting someone through traffic violations and checkpoints that may result in discovery of their immigration status.

The multitudinous and overlapping immigrant policing measures in Atlanta speak to national anxieties over immigration that overlap with issues surrounding race, health, economics, and other social phenomena and point to efforts. The proliferation of legislative and policing techniques to control immigrant populations demands attention to better understand how these techniques affect undocumented immigrants, infiltrate their daily lives and intimate spaces, the extent to which they reach various social spaces and institutions such as health care organizations,
and how they may have hidden effects posing broader social concerns. Accordingly, this research draws from theories of biopolitics and citizenship to examine immigrant policing and its impacts. To advance the research that produced this dissertation, I partnered with numerous Atlanta-based immigrant rights organizations to not only meet and interview undocumented immigrants and immigrant rights leaders, but also participate in the larger immigrant rights movement in Atlanta as a concerted effort to join groups resisting immigrant policing.

**Immigrant Rights Organizations**

Drawing from engaged and activist anthropology methodologies, and inspired by multisited techniques to trace immigrant policing and pathways of legislative power, I joined immigrant rights and health activist organizations in the Atlanta area and participated in their major events, got to know their members, and shared their political causes. I worked most closely with the Georgia Latino Alliance for Human Rights (GLAHR), whose leaders and members shared their experiences with me and welcomed me as a researcher, volunteer, and activist. In addition to GLAHR, I worked closely with members of the Georgia Immigrant and Refugee Rights Coalition (GIRRC), which coordinated communication between a number of organizations expressing a commitment to advancing immigrant rights. I also collaborated with the Hispanic Health Coalition of Georgia (HHCGA), the only statewide organization to focus on Latino/a health; Caminar Latino, a family and intimate partner violence organization; The Clinic for Education, Treatment, and Prevention of Addiction (CETPA), a mental health services and addiction prevention organization; and Cobb United for Change Coalition (CUCC), an organization dedicated to improving the lives of Cobb County residents. Not all of these organizations are represented in this dissertation equally, and my strongest connection was with GLAHR and its members, the GLAHRiadores.
My relationship with GLAHR took root due to my role as a graduate research assistant on a National Science Foundation funded grant, which intentionally built a collaborative and activist research relationship with GLAHR because it was the only immigrant rights organization in Atlanta that was organizing at the “grassroots” of the undocumented community, as well as the most vocal and publicly active. GLAHR was founded in 1999 by a former Mexican official, Alberto, and an activist-teacher who moved from Mexico, Inés. Inés explained that the two of them met when Alberto was looking for leaders to engage in advocacy for the Latino community, and she was looking for activist work. “The first thing we did was deliver a petition to Governor Roy Barnes to get drivers licenses for undocumented immigrants,” Inés recalled, when telling me about GLAHR’s history. “I drove around the state, going door to door and got more than 30,000 people to sign. That’s how I got to know the community, and when I realized that outside of Atlanta, the Latino community didn’t know what was going on in Georgia.” Aiming to spread information to Latino immigrants across Georgia and to begin community organizing efforts, Inés and Alberto formed GLAHR and immediately began putting together political marches and rallies, including a 2001 march in Doraville that petitioned for immigrants to receive driver’s licenses. Inés and Alberto continued to organize political events and Inés routinely made trips across the state to visit communities outside of Atlanta.

Through my participation in GLAHR, I assisted Inés and other members in organizing and attending political marches, contributed to a community-based art installation themed around undocumented immigrants’ rights and experiences, attended weekly meetings of the GLAHRiadores, and actively participated in another Atlanta-area comité popular (neighborhood committee with local leaders). The comité I regularly attended was organized by Doña Julia, an inspiring woman who dedicated countless hours to GLAHR, taught herself how to read as an
adult, and made delicious *pozole*. Julia held weekly meetings in her apartment, where 3-6 neighbors would join us to hear Doña Julia explain what she learned at the weekly GLAHR meeting. Through my participation in Julia’s *comité*, with the *GLAHRiadores*, and in the GLAHR office, I entered Atlanta’s world of immigrant rights activism and met organization leaders, undocumented immigrants, health providers, policy makers, and others who contributed to this research.

**Chapter Summaries**

This dissertation is organized in ten chapters. Following an understanding of immigrant policing as a form of health policy, chapter two provides a history of policies regarding immigrants’ health in the United States, paying specific attention to their exclusion from health services. Chapter two contextualizes how immigrant policing fits into a broader matrix of race-based immigration policies. Extending the discussion about race-based exclusions, chapter three summarizes the theoretical underpinnings of this dissertation, drawing specifically from theories of biopolitics and citizenship. These theories allow for examining how immigrant policing and the dispersal of immigration enforcement regimes produces a type of fear-based governance aiding in fashioning undocumented immigrants into a self-reliant neoliberal citizen who will not make demands upon the state. The fourth chapter discusses the methodological grounding of the research conducted for this dissertation and reviews relevant engaged anthropology literature to describe my position as a researcher with a political perspective that aligned with immigrant rights organizations. I describe how anthropologists can study power by tracing its pathways as a multi-sited ethnography, and provide an overview of the data collection sources, recruitment strategies, and analysis techniques.
Chapters five through ten provide findings organized by key themes. In chapter five, I examine how policy makers conceptualize immigration laws such as HB 87 and discuss some of the challenges with conducting a multi-sited ethnography, such as recruiting legislators who advance anti-immigrant policies. I further describe how HB 87’s lawsuit provision inspired vigilant government agency watching by at least one anti-undocumented immigrant activist, DA King, and his organization, the Dustin Inman Society. Findings from chapter five underscore challenges in studying governmental power and suggest how immigrant policing is an efficient technique of power that manages entire populations as well as individuals. Demonstrating how immigrant policing manages populations through fear, chapter six details how fear of encountering an increasingly localized immigration regime has resulted in some undocumented immigrants avoiding and/or finding alternative sources for care, revealing short-term implications on health and long-term concerns over parallel medical systems that obfuscate larger concerns related to unequal access to care and the impact of law enforcement. Chapter seven extends the discussion of immigrant policing impacting health into family realms, paying specific attention to intimate partner violence and concerns over family separation. Findings from chapter seven point to how immigrant policing can operate within home spaces and destabilize immigrant communities from within intimate settings such as the home. Participant observation experiences in chapter seven suggest how family narratives use problematic discourses of family citizenship to assert some immigrants’ desiringness of remaining in the country.

Shifting attention from undocumented immigrants, chapter eight examines how immigrant policing affects health providers and how health providers respond to immigration laws directly challenging their professional authority. Provider interviews suggest how providers
resist efforts to advance immigrants’ illegitimacy as patients but may be forced into adopting logics of market-based medicine, highlighting how immigrant policing can be a disciplinary technique that works on providers as well as immigrants. In chapter nine, I describe the larger, systemic concerns related to immigrant policing that affect hospitals and potentially the overall medical safety net. Focusing on Grady Memorial Hospital, I describe how public hospitals subsidize private healthcare through receiving “dumped” patients, including and especially undocumented immigrants. Grady’s continued ability to receive dumped patients is complicated by the Patient Protection and Affordable Care Act of 2010, and undocumented patients sent to Grady from other hospitals point to a more serious problem with the US health safety net. I continue to discuss Grady in chapter ten, focusing on the hospital as well as patients with end stage renal disease (kidney failure). This chapter describes the biopolitics of end stage renal disease by tracing the impacts Grady closing a dialysis center and displacing undocumented immigrant patients.

In my final chapter, I summarize the findings from the dissertation, describe my dissemination plan, and provide a reflection on conducting this research. I am appreciative and grateful for the friendships that developed out of conducting the dissertation research, and for the privilege of describing the thoughts and reactions of the undocumented immigrants, health providers, policy makers, and organization leaders I met and who had to live with the consequences of immigrant policing. Despite recent political efforts to provide undocumented immigrants a reprieve from deportation and the announced end of the Secure Communities program (Linthicum 2014), immigrant policing remains a topic demanding research, activist, and political attention as policies aiming to govern immigrants’ lives through fear result in serious
health and family-related consequences. Regardless of recent policy changes, the impacts of immigrant policing remain and merit sustained attention.
CHAPTER TWO
UNDOCUMENTED IMMIGRANTS’ EXCLUSION FROM HEALTH CARE IN THE
UNITED STATES AND GEORGIA AS A CONTINUATION OF
HISTORIC FORMS OF EXCLUSION

Introduction

Health-related impacts of immigrant policing fit into a larger historical and contemporary context of immigration policies that regulate immigrants’ health and access to health services. The estimated 11-12 million undocumented immigrants in the United States represent between 14% and 17% of the entire uninsured population and will account for 25% of all uninsured people after the implementation of the Patient Protection and Affordable Care Act (Livingston 2009; Passel et al. 2013; Sommers 2013; Zuckerman et al. 2011). Although immigrants arrive to the US healthier than their native-born counterparts, their health status declines over time as a result of several phenomena, including changing health behaviors, living and work conditions, and experiencing the effects of living in a racially-stratified society (Abraido-Lanza et al. 2005; Antecol and Bedard 2006; Himmelgreen et al. 2007; McEwen 2004). Moreover, undocumented immigrants may experience disproportionately high burdens of chronic disease when compared to US citizens that directly relate to engaging in dangerous forms of labor. Immigrants working in harmful labor sectors such as construction and migratory farmwork face serious occupational health risks (Arcury and Quandt 2007; Arcury et al. 2000; Arcury et al. 2001; Arcury et al. 2003; Elmore and Arcury 2001). Additionally, because of their vulnerable social position,
undocumented immigrants may be at increased risk for various communicable diseases (Bechtel et al. 1995) and may have mental health concerns from experiencing discrimination in a racially stratified society (McEwen 2004).

Despite myriad health burdens resulting from a vulnerable social position and engaging in dangerous forms labor, undocumented immigrants are unable to participate in most publicly financed health programs, are more likely to lack employer-provided insurance, and are often unable to purchase health insurance with their own funds because they frequently work low wage jobs (American Nurses Association 2010; Kaiser Commission on Facts 2008; Okie 2007). Contemporary examples of exclusion from (and limited access to) medical care, oral health care, and mental health services among undocumented immigrants in the US have been well documented (Carrion et al. 2011; Castañeda et al. 2010; Escobar et al. 2009; Himmelgreen et al. 2004; Himmelgreen et al. 2007; Horton and Barker 2010a; Horton and Barker 2010b; Kline 2010a; Kline 2013; Quandt et al. 2007), which can contribute to lasting health disparities and decreased quality of life. This chapter examines the policies of exclusion that prevent undocumented immigrants from obtaining publicly financed care and situates those policies within the historical trajectory of race-based immigrant exclusion.

In this chapter, I review key federal policies impacting undocumented immigrants’ access to social services, including health care, by reviewing the Social Security Act of 1965, the Emergency Medical Treatment and Labor Act (1986), the Immigration Reform and Control Act (1986), the Personal Responsibility and Work Opportunity Reconciliation Act (1996), and the Illegal Immigration Reform and Immigrant Responsibility Act (1996). I also describe health care reform efforts and impacts on immigrant health care, and juridical justifications for policies excluding undocumented immigrants from certain health services. After reviewing federal
policies impacting undocumented immigrants’ access to publicly financed health care, I discuss how some statutes in Georgia are extensions of both federal and state statutes restricting undocumented immigrants’ access to health services that operate on local levels through policing. Situating these policies in a history of race-based immigrant exclusion that is simultaneously preoccupied with labor needs and concerns over immigrants’ use of public social services allows for examining how immigration policies can divide populations through articulating a vernacular of criminality and undeservingness to social services.

**Federal Policies of Exclusion**

**Background: Race and Immigrant Exclusion**

Labor needs and racial notions of immigrants’ otherness have historically informed US immigration policies and attitudes towards immigrants (Calavita 2000; Chang 2000; Fairchild 2004). Furthermore, US immigration policies in are tied to deep histories of racial exclusion conflated with health status. Bodily inspections of newly arriving immigrants mandated by The 1891 Immigration Act, for example, served to deny entry to racially “other” immigrants based on their health status, perceived inherent morality, mental acuity, and likelihood of carrying a communicable disease (Fairchild 2004). Similarly, migrant workers entering the United States through the Bracero program were required to pass through Public Health Service stations along the US-Mexico border, where they were given vaccines, dusted with insecticides, and inspected for signs of contagious and sexually transmitted diseases and infections (Hoffman 2006: 239).

Further demonstrating how race has figured prominently in immigration policy were race-based immigration quotas established in the early 20th Century. The Emergency Quota Law of 1921, for example, limited the number of immigrants who could enter the United States in an effort to reduce entry of Southern and Eastern European immigrants who were considered "abnormally
twisted, "unassimilable," and "filthy un-American (U.S. Congress 1920:10)” (Calavita 1996a: 288-289). When the law was extended in 1924, it limited the number of immigrants allowed to enter the US to 150,000 people per year, restricting immigration to only 2% of each racial category recorded in the 1890 census in order to drastically limit the number of arriving eastern and southern Europeans who were considered racially (and by extension physically, intellectually, and genetically) inferior (Fairchild 2004: 5).

Amendments to the Immigration and Nationality Act (1965) abolished racial restrictions the national origins quota system created but simultaneously implemented restrictions to immigration into the US from the Western hemisphere (De Genova 2004). The INA amendments specifically capped the number of immigrants from Mexico and any other Western hemisphere country at 120,000 people (De Genova 2004; Massey and Pren 2012), even though the number of Mexicans entering the United States as part of a circulatory labor system averaged near 500,000 per year by the late 1950s (Massey and Pren 2012). In amending the INA, Congress mirrored racial quotas for immigrants set in the 1920s, and drastically reduced the number of Mexicans eligible for legal residency (De Genova 2004; Massey and Pren 2012). Just as Eastern and Southern Europeans were at one point restricted from entry and residency, so too were Mexican immigrants.

Racial exclusions of immigrant groups operated on assumptions of immigrants’ overall biological inferiority, including their health status (Braun 2002; Fairchild), demonstrating how immigrant inspection and poor health historically has been, and continues to be, a basis for denying entry into the country. Racialized notions of disease and social utility that have driven immigration policy (Braun 2002) and have also become articulated in financial terms, as demonstrated by concerns over unhealthy immigrants becoming a “public charge” after entering
the US (Fairchild 2004; Sainsbury 2006). Concerns over immigrants being a public charge are conflated with race and desirability as potential citizens, and anxieties about immigrants being “public charges” persist in contemporary legislation. Some social service legislation underscores financial anxieties about immigrants by demonstrating how some immigrants were denied benefits provided to other US residents. When placed into a context of racially-informed immigration policies, denying some immigrant groups social service benefits suggests that such exclusions are extensions of viewing some groups as desirable potential citizens. Financial concerns over providing services for some immigrants are thus a way of articulating racialized notions of inferiority, and these notions have become formal assertions of exclusion from social services, including publicly financed health care. Starting with the first federal public health program, the Social Security Act of 1965, anxieties of immigrants being a public charge have informed how some immigrants continue to be excluded from health services and resulted in a health program for US citizens but not for certain groups of immigrants. Excluding some immigrant groups from social services is a way of reforming historic race-based exclusions that shifts wholesale actions of exclusion from denying entry to the country to denying social services.

Social Security Act of 1965: The First Step in Federal Health Care Exclusion

The Social Security Act of 1965 created Medicare and Medicaid to serve individuals over 65 and low-income families, respectively. Eligibility for the programs required US citizenship or authorized entry into the United States. As a result, legal permanent residents were allowed participation in the programs, whereas undocumented immigrants were not (Kaiser Commission on Facts 2008). Although immigrants’ health status was a specific interest to federal authorities and a topic of legislation since the late 1800s, the Social Security Act of 1965 was the first federal effort to exclude undocumented immigrants from specific types of health care. By
focusing on denying entitlements to undocumented immigrants, the provisions created in the Social Security Act of 1965 represent a shift in federal legislation and departed from previous systems of exclusion based on race and health status, which targeted immigrants prior to entering the country. Unlike previous forms of immigrant exclusion, such as the Emergency Quota Law, the Social Security Act created a new system of exclusion based on citizenship or immigration status that affected immigrants who had already entered the US instead of those attempting to enter. Excluding undocumented immigrants from national health programs created by the Social Security Act of 1965 thus extended a trajectory of immigrant exclusion beyond concerns regarding health status and into domains of social services. Whereas undocumented immigrants’ health status was once the focus of national immigration statutes, the Social Security Act of 1965 shifted federal legislative focus to immigrants’ eligibility for social services rather than focusing solely on health status and racial difference. This shift marks the first federal effort in excluding undocumented immigrants from specific health services, which had reverberating influences on future social service policies and policies expanding Medicare.

Excluding undocumented immigrants from Medicare and Medicaid inaugurated future policies of exclusion and prevented undocumented immigrants from benefitting from any expansions of Medicare and Medicaid, such as the End-Stage Renal Disease (ESRD) Medicare program. The ESRD Medicare Program (1972) was created to provide a medical entitlement to patients with kidney failure who were not yet eligible for Medicare because of their age but would otherwise qualify for benefits (Campbell et al. 2010). The ESRD exception was carved out of existing Medicare statutes in part to protect patients because at the time of the legislation passing, ESRD was considered the only condition from which a person could die if s/he could not afford care (Blagg 2007), and to relieve providers from having to develop committees of
physicians to decide which patients received dialysis (Greene 1981). In chapter ten, I describe the specific impacts being denied ESRD Medicare has on undocumented patients living in Atlanta, and how excluding undocumented immigrants from this type of care impacts Atlanta’s largest public hospital, Grady Memorial.

In addition to the ESRD Medicare program, other expansions of national health welfare programs also excluded undocumented immigrants from eligibility. The Supplemental Social Security Income Program (SSI) of 1972, for example, created a federally administrated program for disabled persons, including legal permanent residents and refugees, but not undocumented immigrants (Sainsbury 2006). Excluding undocumented immigrants from SSI benefits and ESRD Medicare continued the precedent of excluding undocumented patients from federal benefits created by the Social Security Act of 1965 and reinforced ideas of undeservingness that informed future health and welfare policies favoring citizens, legal permanent residents, and refugees (Sainsbury 2006). Excluding undocumented immigrants from benefits provided to citizens is not particularly surprising, however, as notions of political citizenship often conflate national belonging with political rights, benefits, and protections afforded to citizens by the state (Janoski and Gran 2002). Undocumented immigrants’ exclusion from public benefits thus comports with strictly political notions of citizenship. The resulting impacts of such processes...

---

6 Unlike the alleged “death panels” created from political discussions of the Affordable Care Act, physician panels for dialysis were quite real and had life and death implications.

7 Following World War II, the US established formal refugee policies, starting with the Displaced Persons act of 1948, and the Refugee Act of 1953, which was designed to allow immigrants “escaping communism” entry into the US. The political designation of refugee has had resounding consequences; refugees may be more welcomed into the US than immigrants searching for economic opportunities, and refugees may also have greater access to health services than other groups of immigrants. The Affordable Care Act, for example, prohibits undocumented immigrants form participating in health insurance exchanges, but refugees are able to participate in the exchanges and may qualify for tax credits to purchase health insurance.
deserve analysis, however, as they fit into a larger context of race-based policies of immigrant exclusion and drive health-related inequalities.

As the first federal health care policy and first type of legislation to specifically exclude undocumented immigrants from health services, the Social Security Act of 1965 also served as a harbinger for future policies excluding undocumented immigrants from publicly financed health care and other social services. Health policies following the Social Security Act continue to discriminate based on immigration status and restrict undocumented immigrants from receiving publicly funded services unless they experience medical emergencies. Medical emergency exceptions for undocumented immigrants fall under broader requirements to care for indigent populations, however, including a federal statute mandating hospitals stabilize patients in emergency rooms.

**Relegating Undocumented Immigrants to the Emergency Room**

Despite being denied publicly funded health care due to the Social Security Act of 1965, undocumented immigrants were still able to obtain publicly-funded health services through emergency rooms. Undocumented agricultural workers could also receive primary care through migrant health centers, types of Federally-Qualified Health Centers (FQHCs), as part of the Migrant Health Act (Farmer and Slesinger 1992). This is not to suggest that undocumented migrant agricultural workers had or continue to have adequate health services; on the contrary, a great deal of scholarship shows how undocumented migrant agricultural workers’ health concerns are often connected to limited access to services (Baker and Chappelle 2012; Hoerster et al. 2010; Horton and Stewart 2012; Lukes and Simon 2006; Pérez-Escamilla et al. 2010; Treaster et al. 2006), and limited access extends to all undocumented populations compared to US citizens. Since many undocumented immigrants lack access to primary care, the emergency
room has become an important location for receiving health services, which is made possible through the Emergency Medical Treatment and Active Labor Act (EMTALA) of 1985.

EMTALA is a federal law that prohibits emergency rooms from not treating patients and was passed primarily to stop hospitals from transferring indigent patients from one hospital to another before they were medically stable, a process known as “patient dumping” (Lee 2004). The statute requires hospitals that receive federal funds screen and stabilize any patient who appears in an emergency room regardless of diagnosis, race, ability to pay, national origin, physical ability, or any other characteristic (Lee 2004). If an emergent condition is discovered, hospitals must stabilize patients before transferring them to other hospitals. Prior to EMTALA, any person unable to pay for care, including undocumented immigrants, could be denied care from a hospital emergency room.

EMTALA was the first federal legislation requiring hospitals to treat emergency room patients, but numerous state challenges to patient dumping preceded it, which focused on common law notions of hospitals’ and providers’ duty to care for indigent patients (Lee 2004). When common law efforts failed, states created statutory efforts to end patient dumping, which quickly became problematic since definitions of what conditions constituted an emergency were unclear and few states imposed sanctions for violating patient dumping statutes (Lee 2004). These factors were also responsible for the Hill-Burton Act (1946) failing to prevent patient dumping,\(^8\) (Lee 2004), demonstrating how long dumping indigent patients has occurred. Political interest in designing a federal policy addressing patient dumping developed out of growing public outrage over patients denied services at hospital emergency rooms for severe conditions

---

\(^8\) The Hill-Burton Act was a hospital construction and modernization act and did not exclusively focus on patient dumping. It instead made stopping patient dumping requisite for receiving federal funds for constructing and improving hospitals.
or while pregnant (Lee 2004). A series of hospital patient transfer studies revealed patient dumping from private to public hospitals occurred across the United States, prompting the first draft of EMTALA. When the legislation passed, it provided ways of holding both providers and hospitals accountable for patient dumping through fines, and allowed patients and hospitals receiving dumped patients to bring a cause of action against transferring hospitals (Lee 2004).

Although EMTALA effectively allows for all patients to seek services through emergency rooms, the law has not put an end to all forms of patient dumping, as I describe later in chapter nine, nor was EMTALA passed with immigration or undocumented immigrants as a specific focus. Although EMTALA did not explicitly concern immigrants, it fits into the health care and immigration policy sphere by not excluding undocumented immigrants the way other health care policies did, and by formalizing through legislation an effective “right” to emergency health services for all populations (Lee 2004). Consequently, EMTALA made emergency rooms the only sites of care other than FQHCs where undocumented immigrants can receive publicly financed health services and the legislation provided “presumptive Medicaid coverage” to undocumented immigrants seeking services though emergency rooms (Warner 2012). To financially assist hospitals taking large numbers of uninsured patients they were obligated to stabilize, Congress passed the Disproportionate Share Hospital Program (DSH), which increased Medicaid payments to hospitals with large numbers of uninsured and Medicaid patients (Warner 2012). Together, EMTALA and DSH provide a way for undocumented immigrants to receive publicly financed care, but only in emergency situations. With the passage of the Patient Protection and Affordable Care Act, however, DSH funding and emergency care for undocumented immigrants may be threatened, as I discuss in chapter nine. Although undocumented immigrants ostensibly have access to publicly financed health care through
emergency rooms and lack access to care through many other channels, they are less likely than native-born counterparts to seek care in emergency rooms (Ku and Matani 2001b; Pourat et al. 2014) countering the rhetoric of undocumented immigrants as “drains on the health care system” that informed immigration and welfare reforms in the 1980s and 1990s. The “public charge” arguments specifically focusing on health care played a significant role in neoliberal reforms beginning in the 1980s, which further codified undocumented immigrants’ exclusion from publicly financed health services.

**Immigration and Health in Neoliberal Reforms**

Undocumented immigrants’ prohibition from receiving non-emergency publicly financed health care became further solidified with immigration and welfare reforms in the 1980s and 1990s. The Immigration Reform and Control Act of 1986 (IRCA), for example, provided a pathway to citizenship for some undocumented immigrants but made citizenship contingent upon proving they had never received federal public benefits such as Medicaid (Huang 2008). IRCA’s restrictions resulted in confusion among some immigrants who received state-level assistance and continues to deter some immigrants from using state or federal benefits, even if they are eligible and need the assistance (Huang 2008). Further restricting undocumented immigrants’ eligibility to obtain health services were The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA), both of which passed in 1996.

Synonymous with “welfare reform” of the 1990s, PRWORA remains one of the most sweeping legislative changes to social services in US history that resulted in new policies emphasizing neoliberal notions of personal responsibility. The health-related impacts of PRWORA extend well beyond undocumented immigrants, and a great deal of social science
literature has explored these impacts, critiquing neoliberalism generally (Coburn 2000; Morgen and Maskovsky 2003; O'Connor 2000; Viladrich 2012)\(^9\). Like other neoliberal reforms, discourses surrounding PRWORA included economic scapegoating of the poor and racial minorities, especially African American women and Latina women, whose alleged “failure to comport with market logics” resulted in purportedly abusing social services, being dependent on welfare, and using children to gain access to entitlement programs (Chang 2000; Chavez 1997; Maskovsky 2005; O'Daniel 2008). Immigrants’ large burden of scapegoating related to PRWORA is best demonstrated by lawmakers writing into the legislation that “It is a compelling government interest to remove the incentive for illegal immigration provided by the availability of public benefits” (Kullgren 2003; United States Congress 1996).

By reducing federal welfare expenditures and thereby ending “cultures of dependency” among the poor and “removing incentives for illegal immigration,” PRWORA promised to save $54.1 billion over six years, half of which resulted from cutting services to authorized and undocumented immigrants (Ellwood and Ku 1998; Fairchild 2004). The cost savings promised through PRWORA were specifically made possible by prohibiting all state aid to undocumented immigrants unless states made other provisions (Fairchild 2004) and restricting authorized immigrants entering after August of 1996 from receiving Medicaid coverage in the first five years of residency unless they experienced a medical emergency (Ku and Matani 2001a). Authorized immigrant children who arrived after 1996 were also ineligible for health services such as Medicaid and the State Child Health Insurance Program (SCHIP) for a period of 5 years (Huang et al. 2006) PRWORA thus effectively restricted federal benefits to all immigrants and created eligibility criteria repeated in future entitlements legislation such as the Patient Protection

\(^9\) Rather than provide an overview of scholarship on PRWORA, this chapter limits health-related discussions about PRWORA to undocumented immigrants.
and Affordable Care Act (Castañeda Forthcoming). Furthermore, in restricting public benefits to immigrants, PRWORA rearticulated racial notions of desirability and concerns over immigrants becoming public charges that were more overt in immigration inspection policies, but mirrored the Social Security Act of 1965 by focusing on restricting services to immigrants already present rather than attempting to control which immigrants entered the country.

Prior to PRWORA, citizens and legal residents shared equal access to public programs, but changes in PRWORA divided all immigrants from citizens and further subdivided immigrants into qualified and nonqualified aliens, making residency or citizenship a requirement for receiving entitlements affected by the legislation (Viladrich 2012). Limiting authorized immigrants’ access to Medicaid made some immigrants more dependent on FQHCs and clinics funded through Title V and Title X (maternal and child health and family planning, respectively) public health service programs (Warner 2012). On a state level, PRWORA gave states nearly total control of welfare programs, which allowed for some states and local governments to potentially create more benefits to undocumented populations (Marrow 2012), but simultaneously created more stringent work requirements and limits to receiving benefits (Ellwood and Ku 1998).

Similar to federal benefit restrictions for authorized immigrants created by PRWORA, IIRIRA created new restrictions to social services for undocumented immigrants. The welfare provisions of IIRIRA extended beyond health services and specifically barred undocumented immigrants from receiving any type of federal benefit, including nutritional and housing program benefits, work and professional licenses, contracts, disability benefits, and other forms of

---

10 The Florida Supreme Court recently decided on this issue and used PRWORA its opinion denying an undocumented immigrant the ability to receive a license to practice law. The full opinion can be found here: http://www.floridasupremecourt.org/decisions/2014/sc11-2568.pdf
assistance. The law also made it more challenging for authorized immigrants to receive public benefits after the five-year residency requirement and further strengthened the “public charge” exclusions created in earlier immigration laws (Clark 2008; Johnson 2009). Under changes made in IIRIRA, when applying for benefits, an immigrant must include a sponsor friend or family member whose income is included in calculating benefit eligibility (Huang 2008). These restrictions responded to public and political accusations of undocumented immigrants using state resources demonstrating how economic justifications for limiting undocumented immigrants’ social services informed provisions of PRWORA and IIRIA. Together, IIRIA and PRWORA have resulted in decreased usage of social services such as Medicaid among some immigrants eligible for services due to confusion about eligibility and other factors (Hagan et al. 2003). As a result, immigrants eligible for Medicaid services in some locations have devised alternate strategies to receiving care rather than use public services to which they are entitled (Hagan et al. 2003).

In addition to restricting undocumented immigrants’ ability to receive public benefits, IIRIRA established numerous provisions concerning border enforcement, stiffer penalties for smuggling and documentation fraud, changes in deportation proceedings, employer sanctions for hiring undocumented immigrants, refugees, and asylum seekers (Fragomen 1997). The law also amended the Immigration and Nationality Act by adding section 287(g), a program in which the federal government agrees to grant local police permission to enforce immigration laws, which I describe in greater detail below. Components of PRWORA and IIRIRA demonstrate underlying neoliberal logics of self-reliance that informed the legislation and surrounded immigration and social services (Sainsbury 2006). Furthermore, these reforms are examples how economic concerns have become conflated with racialized notions of immigrants’ otherness that have
resulted in excluding undocumented immigrants from social services. This form of exclusion has been further codified in health reform efforts.

**Immigration and Health Care Reform**

Since the creation of Medicare and Medicaid, there have been two efforts to reform health care in the United States, starting in the 1990s. Between 1993 and 1994, President Bill Clinton and First Lady Hillary Clinton campaigned for sweeping reforms to the US health care system. Clinton reform efforts in the early 1990s failed and ultimately no reform legislation passed, but in response to the reform failure, congressional Democrats and Hillary Clinton drafted a smaller health care initiative focusing on children, SCHIP, which passed in 1997 and represented an incremental step to health care reform (Oberlander and Lyons 2009). As part of a federal and state cost-sharing program, SCHIP expanded Medicaid to children in low-income families, and since eligibility focused on children, US-citizen children with undocumented parents were eligible for the program (Kaiser Commission on Facts 2006). Despite children’s eligibility, however, some undocumented immigrant parents may not enroll their children in SCHIP or take their SCHIP enrolled children to providers due to fears of being reported to immigration authorities (Baumeister and Hearst 1999; Castañeda and Melo 2014; Huang et al. 2006; Ku and Matani 2001a; Kullgren 2003). In addition to covering children, SCHIP also allowed for states to use Medicaid funds to provide prenatal health services to undocumented pregnant women (Huang 2008), but this was not explicitly permitted at the time of the program’s creation.

SCHIP-reimbursed prenatal care for undocumented immigrant women was not written into the law or developed later through altruistic notions of proving care to all populations, but rather efforts to intervene on the behalf of a potential unborn US citizen. Prenatal care for
undocumented women provided through SCHIP only occurred after the Centers for Medicare and Medicaid Services (CMMS) changed definitions of “child” to include unborn children, effectively granting personhood to fetuses for treatment purposes and providing SCHIP benefits to fetuses undocumented women carried (Huang 2008). Moreover, undocumented women’s SCHIP coverage was discovered by accident when some states were challenged after submitting reimbursement claims to CMMS for providing care to undocumented women and their unborn citizen children (Huang 2008). SCHIP coverage for undocumented women was therefore not a legislative effort intended to expand health care to undocumented women, but rather undocumented women were able to receive care as an unintended consequence of granting personhood to the citizen fetuses they carried. Access to health services for pregnant undocumented immigrant women was the consequence of a gendered policy valuing an unborn body that was granted notions of political citizenship by virtue of the promise of being born into the US.

During the most recent health care reform attempt under the Obama administration, the intersection of immigration and health care as two politically contentious topics surfaced, particularly in 2009, when President Obama addressed joint houses of Congress and the nation about what would become the Affordable Care Act (ACA) (Heyman 2009). During his address, the President asserted that undocumented immigrants would not receive publicly funded health services through health care reform, prompting Representative Joe Wilson of South Carolina to shout “You lie!” in response. Wilson’s outburst underscored political rhetoric regarding undocumented immigrants’ undeservingness to publicly financed health services, especially during a time when health care inflation resulted in large numbers of uninsured and underinsured US citizens even though the US spends more per capita on health care than any other country.
(Marmon and Oberlander 2010). In the context of rising health care costs and numbers of uninsured (Horton et al. 2014), restrictions to undocumented immigrants were written into the final version of the health care reform legislation. When the ACA passed, the law continued to prohibit undocumented immigrants from receiving Medicaid (Sommers 2013; Warner 2012; Zuckerman et al. 2011) and further prohibited undocumented immigrants from participating in the newly-created health exchanges and from purchasing health insurance with their own funds (Cartwright 2011: 479). This provision is likely due to the public benefit bans created in PRWORA (Castañeda Forthcoming; Liebert and Ameringer 2013), but as part of a sweeping health care reform aimed at lowering health care costs, including undocumented immigrants in health care exchanges could have been a financially beneficial decision and potentially reduced overall health expenditures.

In addition to directly prohibiting purchasing insurance through exchanges, full implementation of the ACA may have more indirect impacts on undocumented immigrants as it may result in reducing DSH funds that reimburse hospitals for providing care to undocumented patients, which I explain in greater detail in chapter nine. Shrinking DSH funds in the medical safety net system suggest greater health disparities for minority patients, including, but not limited to undocumented immigrants (Horton et al. 2014). Beyond impacting undocumented immigrants, the ACA also restricted access to care for some authorized immigrants. Similar to restrictions established in PRWORA, immigrants who have been in the United States less than five years are not eligible for health care services through the insurance exchanges, continuing the precedent PRWORA established of separating immigrants from citizens.

**Racialized Criminality of Undocumented Immigrants**

Undocumented immigrants’ exclusion from health services is part of a historical
trajectory of exclusion based on race, health status, and concerns over becoming a public charge, especially in a context of burgeoning healthcare costs and shrinking state and federal budgets. In the most recent decade, conflating race and economic concerns over undocumented immigrants receiving social services has also included discourses of criminality, inspiring federal and state legislation. Several social scientists have described how legislation has “framed” (Goffman 1974) undocumented immigrants in specific ways that promote policies built around stereotypes and notions of undeservingness to social services (Becker et al. 2000; Fujiwara 2005; Horton 2004; Morgen and Maskovsky 2003; Viladrich 2012; Yoo 2008). As Willen notes, vernacular frames, such as criminality, are situated within a “localized moral economy” involving perceptions of value, effect, expectation, inclusion and exclusion, deservingness and undeservingness that contribute to perceptions of undocumented immigrants (Willen 2014). Frames can serve as a filter for complex social phenomena, amplifying, distorting, and otherwise augmenting them (Willen 2014). In the US, frames of criminality, security, and economic wastefulness have guided a host of recent immigration laws and provided juridical justifications for excluding undocumented immigrants from health care and other social services. These frames may serve to mask the history of racial otherness that has informed US immigration policies and obfuscate transnational economic and political relationships related to migration. Moreover, discursive frames of criminality and immigrant illegality, specifically, simplify reasons for migration to notions of individual choice, serving to further deny sets of rights and entitlements to undocumented immigrants precisely because of their purported “choice” to engage in criminal activity (Yarris and Castañeda Forthcoming).

Although criminalizing immigrants through racial constructions has a long history in US immigration policies and subsequent social service policies (Calavita 1996a; Calavita 2000;
Calavita 2005; De Genova 2004; Fairchild 2004; Johnson 2009), recent discourses of immigrants’
criminality informing social service policies began with neoliberal reforms such as IRCA
(Stuesse 2010a) and PRWORA (Horton 2014). Much of the debates shaping PRWORA and its
provisions related to immigrants centered around ways in which undocumented immigrants were
constructed as “career criminals” by not only entering the US through unauthorized means, but
also allegedly counterfeiting US documents, not paying taxes, and using taxpayers’ resources by
using public entitlements (Viladrich 2012). These arguments failed to acknowledge that “illegal
immigration” is largely driven by labor demands and is related to US policy changes. The
immigration caps created by the INA, for example, and the cancelation of the Bracero Program
increased unauthorized immigration from Mexico since relationships between Mexican migrant
workers and employers remained but immigration from Mexico faced new restrictions (Calavita
1996a). As Massey and Pren write: “In sum, illegal migration rose after 1965 not because there
was a sudden surge in Mexican migration, but because the temporary labor program had been
terminated and the number of permanent resident visas had been capped, leaving no legal way to
accommodate the long-established flows” (2012: 3). Despite being labor-driven, increases in
unauthorized migration resulting from policy changes have led to unauthorized immigrants being
viewed as criminal because of their form of entry into the country (De Genova 2004).
Furthermore, racial constructions of immigrant criminality intensified after September 11, 2001
(Fairchild 2004), and increased policing and deportation efforts have been justified in a post-
responding to undocumented immigrants’ alleged criminality have informed policies focusing on
interior immigration enforcement efforts, such Section 287(g) of the Immigration and Nationality
Act (1996) and Secure Communities (2008). These laws decentralize immigration enforcement
authority and disperse enforcement into local spaces (Coleman 2009).

Section 287(g) of the Immigration and Nationality Act of 1996 allows local police to enforce federal immigration laws through memorandums of agreement (MOAs)\textsuperscript{11} with Immigration and Customs Enforcement, the principal investigative branch of the Department of Homeland Security (United States Department of Homeland Security, no date #1890}. By deputizing local law enforcement officials through MOAs, 287(g) permits a type of localized immigration enforcement that extends powers traditionally given to federal authorities to local law enforcement\textsuperscript{12}. There are three models through which 287(g) works in practice: the jail enforcement model, task force model, and hybrid model. The jail enforcement model allows 287(g) trained officers to question already arrested inmates about their immigration status and communicate findings with ICE (Capps et al. 2007). Whereas the jail enforcement model limits officers’ authority to detention centers and jails, the task force model grants officers authority to inquire about immigration status, issue warrants for immigration status violations, and act on search warrants while conducting routine police activity “in the field” (Capps et al. 2007). The hybrid model combines both programs in the same jurisdiction. (Parker No Year) Although section 287(g) has no explicit impact on undocumented immigrants’ health care, it serves as a mechanism of localized immigrant policing and works in concert with other state and federal laws to impact undocumented immigrants’ mobility, ultimately impacting their willingness to seek health services and in some cases change health behaviors, as I describe in greater detail in

\textsuperscript{11} Also referred to as memorandums of understanding.

\textsuperscript{12} Although local jurisdictions have historically been authorized to enforce criminal immigration crimes, such as human trafficking or reentry after deportation, only the federal government had the authority to act on civil immigration violations, such as unlawful presence. MOAs created through 287(g) broaden local authorities’ ability to enforce civil violations and blend federal and state enforcement activities. This is explained in an ACLU presentation titled: “Local Enforcement of Immigration - Secure Communities & 287(g). American Civil Liberties Union of North Carolina,” by Katy Parker.
chapters six and seven. Like 287(g), Secure Communities is a federal immigration law that works on local levels. The program matches fingerprints from jail inmates with immigration databases to assess detainees’ immigration status. Together, 287(g) and Secure Communities can have health-related impacts on undocumented immigrants and their families.

Other policies created ostensibly for security purposes have been tied to undocumented immigrants’ ability to receive health services, tying assumed criminality with use of health services. For example, changes to Medicaid in the 2005 Deficit Reduction Act (DRA) directly followed foundational ideas guiding the REAL ID Act, when Congress passed (and the Centers for Medicare and Medicaid implemented) a policy requiring Medicaid beneficiaries to prove their citizenship before receiving benefits (Ku and Pervez 2010). The Real ID Act requires states to check driver’s license applicants’ citizenship or immigration status before issuing licenses, ultimately restricting undocumented immigrants’ ability to receive drivers’ licenses and consequently impacting their mobility. Restricted access to drivers’ licenses plays a key role in immigrant policing, as police can arrest a person for driving without a license and once in jail, their fingerprints can be matched using the Secure Communities program. If a match is not found, Immigration and Customs Enforcement (ICE) officials can be notified and may question an arrestee to determine his or her immigration status.

Copying ideas for tighter documentation that were present in the Real ID Act, then-Congressman Nathan Deal and Congressman Charles Norwood of Georgia, following the recommendation of Governor Sonny Purdue, proposed that a section of the 2005 DRA require proof of citizenship for Medicaid applicants. Medicaid changes in the DRA are particularly

---

13 The political agents behind the DRA Medicaid changes are of particular interest to this dissertation because they are key Georgia politicians who played a significant role in Georgia’s immigration laws, and there are several similarities between Georgia law and the 2005 Medicaid
troubling because there was no evidence to support Medicaid fraud among immigrants and the policy ultimately resulted in US citizens losing insurance because of barriers the legislation created (Ku and Pervez 2010). Moreover, the policy was used as a political tactic to divide beneficiaries from immigrants and frame the law as a form of punishment for undocumented immigrants. The law had no real impact on undocumented immigrants, since they were ineligible for Medicaid anyway, and authorized immigrants already had to show proof of legal permanent residency for five years. However, the law used two particular legislative tactics to shape discourse regarding undocumented immigrants as criminals (Ku and Pervez 2010; Pierson 1996). “Punishing undocumented immigration” was such a focus for many 2005 congressional members that the House Immigration Reform Caucus, of which Deal and Norwood were members, promoted punishing undocumented immigrants and eliminating citizenship for children born in the United States to undocumented parents (Ku and Pervez 2010).

Interior immigration enforcement measures such as 287(g) and Secure Communities, changes to the DRA demanding proof of legal status to receive benefits, and concerted efforts to “punish criminal aliens” are all examples of policy-related objectives to reinforce undocumented immigrants as criminal other. Just as inferior health status was once conflated with racially other immigrants that justified immigrants’ inspections to ensure they were not to become public charges, undocumented immigrants criminality has become associated with their identities and policies responding to them being criminal public charges have resulted in localized policing efforts and exclusion from social services.

changes. One similarity is the way that the Medicaid changes in the DRA required Medicaid applicants to sign statements under penalty of perjury that they were citizens, a theme that surfaces in Georgia laws targeting immigrants.
Counterarguments

Although ideas of criminality and accusations of draining public resources have informed juridical efforts to exclude undocumented immigrants from publicly financed health services and other benefits, several scholars have provided juridical justifications for providing publicly financed services to undocumented immigrants. Many of these rationales rest on administrative law pointing to public health authority resting within states, and further arguing that undocumented immigrants should receive health care as a way of protecting population health. Focusing on federal and state authority to regulate health, some scholars have argued that PRWORA represents a type of federal overreach that violates legal understandings that governing health is within the authority of states, not the federal government (Gostin 2008; Kullgren 2003). Stipulations on restricting health care conflict with states’ “police powers,” which affords them the authority to regulate residents’ health and welfare (Fee 1998; Kullgren 2003). A state’s ability to regulate population health through police powers was determined from the Jacobson v. Massachusetts Supreme Court Case (Gostin 2008) and is constitutionally inferred since it is not explicitly written in the Constitution as a federal power. PRWORA and other federal restrictions on denying care to undocumented immigrants thus conflict with legal precedent established with Jacobson and constitutional understandings of states’ police powers.

In addition to establishing legal authority for states to regulate population health through police powers, some public health scholars have argued why states should use police powers to provide undocumented immigrants with publicly financed health care. These arguments include asserting that not providing public services to undocumented immigrants can endanger child citizens, put the broader population at risk for communicable disease, and that denying preventive services but providing emergency care is not putting public funds to their most cost-
effective use (Kullgren 2003). As Viladrich (2012) notes, several public health scholars have argued for providing preventive health services to immigrants as a cost-effective way to avoid larger costs of denying care to specific groups of people (Berk 2000; Goldman et al. 2005; Ku 2009; Mohanty et al. 2005; Muennig and Fahs 2002; Okie 2007) or that undocumented immigrants’ health care utilization rates are lower than citizens’ (Berk 2000; Ortega et al. 2007), and contribute to fewer health care costs in relation to their population size (Goldman et al. 2006).

Public health arguments promoting undocumented immigrants’ eligibility to receive publicly financed health services are a type of counter- framing exercise that draw on frames of “cost saving” and “protection” (Viladrich 2012). Although arguments for including undocumented immigrants in public benefits may be efforts to counter harmful policies, these arguments do not necessarily escape some of the harmful rhetoric that result in undocumented immigrants’ racialized otherness that requires population protection measures as if undocumented immigrants were “vectors of disease.” As Willen, Mulligan, and Castañeda note, efforts to increase care for undocumented immigrants should not focus on immigrants as “unidirectional carriers of disease” (2011: 332). Avoiding potentially otherizing rhetoric, some health scholars have argued for social justice-inspired legislation that allows affordable access to health services for all members of society irrespective of immigration status (Gardner 2007) or have argued for an “emancipatory praxis” in health services, (McGuire and Georges 2003), not unlike the type of call to action medical anthropologists have sought in addressing unjust systems.

---

14 I use this term somewhat figuratively and literally since epidemiologically vectors can be any agent carrying and transmitting a pathogen to another but are typically seen as insects or non-human agents that merit control and containment. Although vectors are often considered non-human carriers of disease, the notion of immigrants as vectors captures how they were framed as almost subhuman because of their racial difference, health status, etc.
of health service provisioning and unequal social conditions resulting in poor health (Singer 1995). These efforts do not necessarily counter juridical arguments of exclusion targeting undocumented immigrants other than perhaps borrowing from the International Declaration of Human Rights, which is not legally enforceable in the United States since the United States has not ratified numerous international human rights treaties (Human Rights Watch 2009). Accordingly, juridical counterarguments to undocumented immigrants’ exclusion may best focus on state police powers in order to effective challenge legal exclusions and avoid reproducing racialized constructions of undocumented immigrants as unhealthy “others.”

**Immigration Legislation in Georgia**

In addition to federal efforts controlling immigration, a growing number of state legislatures have passed immigration statutes. Social services, including publicly funded health care, have been the foci of several state immigration laws, and although some local governments have expanded access to services for undocumented immigrants (Marrow 2012), but many of them have restricted access to public services, including health care (Clark 2008). One of the earliest forerunners of contemporary state immigration laws targeting undocumented immigrants’ use of social services was California’s Proposition 187. The California law passed by voter referendum in 1995 and made undocumented immigrants ineligible for a wide array of public services, including education and health services (Colino 1995). Undocumented-immigrant children were barred from enrolling in public schools, school administrators were required to inspect children’s immigration status, and undocumented patients were denied state funded emergency care, prenatal care, and vaccinations (Calavita 1996a: 291). As a result of the initiative, undocumented immigrants’ utilization of social services such as health care and public education declined (Berk et al. 2000; Fairchild 2004). Although ultimately found to be
unconstitutional, the legislation successfully crafted a message of exclusion for undocumented immigrants (Calavita 1996a) that reemerged more recently in other state laws.

Starting the deluge of recently-enacted state immigration laws, Arizona passed SB 1070 in 2009, adopting a new strategy of sending a message of exclusion to undocumented immigrants that centered on law enforcement and undocumented immigrants’ purported criminality. SB 1070 mandates that immigrants carry immigration documents with them at all times and compels law enforcement officials to assess an individual’s immigration status. Similar laws have also passed in Alabama, Georgia, Indiana, South Carolina, and Utah (Sacks 2012), and Mississippi was at one point expected to pass similar legislation (Phillips 2012). While these states have enacted legislation similar to Arizona’s SB 1070, other states have also passed immigration-specific legislation, and a total of 164 anti-immigrant laws have passed state legislatures nationwide in 2010 and 2011 (Gordon and Raja 2012).

The growth of state immigration legislation reflects a rising trend of nativism that began in the US in the 1970 and greatly increased in the 1990s and through the 2000s (Calavita 1996a; Huang 2008; Ku and Pervez 2010; Perea 1997). A great deal of immigration rhetoric informing policy action focuses on nativist constructions of race and population concerns, demonstrated by organizations responsible for drafting model immigration legislation that has been adopted in state legislatures. The Federation for American Immigration Reform (FAIR), for example, is one of the largest anti-immigrant organizations drafting legislation, including California’s Proposition 187 (Huang 2008). In Georgia, FAIR drafted a report entitled “The Costs of Illegal Immigration to Georgians” arguing undocumented immigrants cost Georgia approximately $1.6 billion a year, $210 million of which was health care costs, including obtaining Medicaid through false documents, and the report all but commended Georgia officials for passing
legislation and entering 287 (g) agreements to curtail these costs through various enforcement measures (Martin 2008a).

As the FAIR report suggests, Georgia, like other states, has passed immigration laws that have resulted in and are inspired by framing undocumented immigrants as drains on social services and as inherently criminal. Discourses of criminality and economic wastefulness appear in popular media and in politics, as demonstrated by an article appearing in the “readers write” section of the Atlanta Journal Constitution. The author of the article describes how undocumented immigrants “steal resources” presumably from citizens and get away with unlawfulness: “If I sneak into a place of business and steal goods for a long time, I am subject to being arrested and jailed. But, if I sneak across the border and steal free education and free health care, I then can march and demand that I should be allowed to continue my theft with no penalty” (For the Journal-Constitution 2011). Echoing the charge that immigrants are drains on social services but in a political context, Georgia State Representative Matt Ramsey claimed that undocumented immigrants’ use of health services has strained the health system and Georgia taxpayers’ pocketbooks: “Illegal immigrants using the ER for nonemergency reasons is a huge drain on the health care system --- impacting hospitals, insurers and consumers alike” (Williams 2011a). These two examples represent myriad political and popular media statements about undocumented immigrants’ criminality and economic irresponsibility that informed numerous immigration laws restricting undocumented immigrants’ access to social services.

Following examples from California’s Proposition 187 and Arizona’s SB 1070, in recent years Georgia has passed a series of immigration laws restricting undocumented immigrants’ access to social services, including welfare benefits and specific forms of education. Some of these statutes were directly related to the 287(g) program operating in four Atlanta-area
counties\textsuperscript{15} (US Department of Homeland Security: Immigration and Customs Enforcement No Date). For example, in 2010 Georgia received national attention for its 287(g) and Secure Communities jurisdictions, when Jessica Colotl, a Kennesaw State University student, was arrested for driving without a license and turned over to immigration authorities through the 287(g) program. Colotl’s situation sparked local and national debate about undocumented immigrants being admitted into public universities and shed national light on the plight of undocumented youth. Locally, her story led some legislators to demand that Georgia universities check students’ immigration status prior to admission and inspired the first drafts of legislation restricting undocumented immigrants’ ability to attend certain Georgia universities. Moreover, her story brought attention to local police practices, and how undocumented immigrants’ interactions with local police may lead to potential deportation in 287(g) and Secure Communities jurisdictions. As a result of Colotl’s situation, the Georgia board of Regents, receiving pressure from the state legislature, banned undocumented students from Georgia’s flagship universities. Education measures continue to be debated and discussed in Georgia legislature, including proposed laws to ban unauthorized students from all of Georgia’s public universities and technical colleges (HB 59 from legislative year 2012, for example). These measures have inspired education-oriented activism, giving rise to an “underground university,” Freedom University, in which faculty from one of Georgia’s flagship institutions offer free classes for undocumented immigrants.

In addition to focusing on education, Georgia followed REAL ID standards in restricting undocumented immigrants from obtaining a drivers’ license, and another statute dramatically criminalizes driving without a license. Under SB 350 (2008), four no operators’ license arrests

\textsuperscript{15} Cobb, Gwinnett, Hall, and Whitfield Counties participate in 287(g).
within five years is considered a felony, increasing undocumented immigrants’ risk of becoming felons as they are unable to obtain drivers’ licenses and are more likely to be arrested for not having a valid license while driving. Through the Secure Communities program, an arrest for driving without a license translates to documentation status discovery, and 287(g) agreements allow for enforcing federal immigration laws. As a result, Georgia’s drivers’ license statutes and associated policing have impacted undocumented immigrants’ mobility (Stuesse and Coleman 2014), and as I discuss in later chapters, have constrained their ability to get to work, drive children to school, and seek health services.

Georgia’s restrictive education and driver’s licenses statutes reflect an effort to constrain immigrants’ mobility long term and short term. By restricting driving in a place with an inadequate public transportation system, undocumented immigrants’ mobility is limited and by extension so is the ability to work and seek health services. Denying access to education, framed as cost reduction, ultimately limits long-term economic and social mobility since education level may limit job and economic opportunity. While these statutes directly impact immigrants’ spatial and social mobility—and by extension their use of social services such as health care—they were not as explicitly restrictive as laws aimed to exclude undocumented immigrants from public services, such as HB 87, Georgia’s version of Arizona’s SB 1070.

Following examples set by Proposition 187 and SB 1070, the Georgia legislature passed the “Illegal Immigration Reform and Enforcement Act of 2011,” more commonly referred to as HB 87. Governor Nathan Deal, who championed Medicaid changes in the 2005 DRA that targeted undocumented immigrants, campaigned on the promise of passing anti-immigrant legislation in Georgia and fulfilled his promise when signing HB 87 into law. HB 87 requires undocumented immigrants carry proof of their legal status at all times and authorizes local law
enforcement to request proof of legal status from anyone suspected of being undocumented. When HB 87 passed, it also criminalized any form of assistance to undocumented immigrants, including transporting an undocumented person in a personal vehicle or providing any kind of non-emergency health service using public funds. Although the 11th Circuit Court of Appeals overturned the specific provisions about assisting undocumented immigrants, the rest of the law remained intact, including officers’ authority to request proof of immigration status from anyone suspected of being undocumented. Despite specific provisions being overturned, the law created an effect of fear among some undocumented immigrants and confusion among some health providers, as I describe in chapters six, seven, and eight.

After Governor Deal signed HB 87 into law, Latino immigrants began leaving the state in such large numbers that the agricultural industry suffered a worker shortage and crops began rotting in fields. To address this problem, Governor Deal bussed prisoners to farms to pick crops, but after less than half a day’s work, prisoners refused to pick any more (Powell 2012). As a result of the labor shortage related to HB 87, Georgia’s agricultural industry, the largest sector of the state economy, lost more than $1 billion in 2010 (Paluska 2011). The law also created an oversight board, the Immigration Enforcement and Review Board (IERB), to ensure compliance with all immigration-related policies, staffed by volunteers the Governor and Lt. Governor appointed to the position, which I describe in more detail in chapter five.

This dissertation ultimately examines how federal and state statues and local police practices come together to impact undocumented immigrants’ health and ability to seek health services in Atlanta. Scholarship documenting family impacts, changes in mobility, and broader community impacts of Secure Communities and 287(g) discusses how these policies disperse immigration enforcement into local spaces and reproduce the criminalization of immigrants as a
social other (Arnold 2007; Coleman 2009; Coleman 2012; Coleman and Stuesse 2014; Martinez and Slack 2013; Slack et al. 2013; Stuesse and Coleman 2014). Social reproduction of criminality and dispersal of border enforcement into everyday spaces does not, however, pay specific attention to health-related impacts of localized immigration enforcement regimes. On the other hand, scholarship examining 287(g) and Secure Communities through a health lens has focused on how these policies impact health services and have mental health impacts on immigrants and their families (Alexander 2014; Mann et al. 2014), but does not adequately draw attention to ways that federal statutes, state policies, and local policing interact.

Accordingly, this dissertation responds to the need to examine immigration enforcement and its negative effects on health (Castañeda et al. 2015). Research from this dissertation further responds to calls for research examining how state-level immigration policies impact immigrant health (Hardy et al. 2012) and further examines how state laws fit into a web of immigration enforcement woven together by federal statutes, state laws, and local police practices. Georgia’s immigration laws work in concert with local police practices and federal policies such as 287(g) and Secure Communities to form a type of localized immigration enforcement that extends into everyday spaces. The combination of state immigration laws, Secure Communities, 287(g), and local police practices ultimately impact undocumented immigrants, their families, health providers, and the health care delivery system, as I demonstrate in subsequent chapters in this dissertation.

**Conclusion**

State and federal legislation, and local police practices in Atlanta, fit into broader political systems working to exclude undocumented immigrants from health and other social services as part of a historic trajectory of race-based immigration policy. Federal and state
statutes not only service to politically codify undocumented immigrants’ exclusion from publicly
financed health services, but further serve to assert undocumented immigrants’ inherent
criminality in an effort to shape rhetoric regarding their undeservingness to social services,
thereby garnering additional support for legislation that continues to promote otherizing
processes. Exploring the history of immigrant criminality and race-based deservingness
underscores how immigration status, and undocumentedness in particular, operates in similar
ways to socially-produced rationales for discrimination and inequality, such as race, class, and
gender (Menjívar 2014). Policies of social service exclusion are thus extensions of historic forms
of excluding immigrants based on racialized constructions of otherness. Examining
contemporary policies of exclusion in the context of health care reform is especially important as
it can reveal broader, system-wide failures in market-based medicine as well as deepen health
inequalities and disparities among racial minorities (Horton et al. 2014).

As this chapter has demonstrated, immigration status and undocumentedness is rooted in
a history of race and social service exclusion that has provided a contemporary basis for how
examining how undocumented status itself is a constructed form of inequality not unlike race and
gender. Having provided the context of immigrant exclusion from health care in the United
States and explained that policies of exclusion are often framed within discourses of race and
criminality, I next examine theories (Chapter three) and methodological choices appropriate for
exploring these ideas (Chapter four). The situation in Georgia underscores a biopolitics of
immigration that speaks to the construction of “alien” others, how whiteness and non-whiteness
become legally constructed, and how us-them binaries can be legally drawn (Johnson 1997) to
shape notions of deservingness to health services.
CHAPTER THREE
THE BIOPOLITICS OF IMMIGRANT POLICING:
GOVERNING THROUGH FEAR TO PRODUCE AN IDEAL NEOLIBERAL CITIZEN

Introduction

Understanding immigration policies that arrive out of histories of racially constructing immigrants as others and designing policies that exclude immigrant groups from social services requires a theoretical framework capable of exploring race and governing populations through techniques of power. In this chapter, I examine theories of power, intersectionality, citizenship, and health-related deservingness that address the historically, politically, and economically driven processes of discrimination that have made undocumented immigrants a racialized other whose racially constructed criminality contributes to their accepted undeservingness of social services. I specifically focus on biopolitics and citizenship as they relate to forms of exclusion or ideologies of difference and argue that restrictive immigration laws born out of biopolitical exercises are a technique of power that attempt to construct the ideal neoliberal immigrant citizen who refuses to make health-related demands upon the sovereign authority and finds alternate routes to receiving social services such as health care. Immigration policies are therefore a form of neoliberal governmentality, and theories of biopolitics and citizenship reveal processes of governmentality and can offer ways of intervening within a system that fosters inequality, including health inequities.
To advance this argument, I draw from Foucault’s definition of power and notion of biopolitics to discuss how biopolitics functions as a vehicle of social division, paying specific attention to race, nationality, sex, and social class. Further examining how other social scientists have explored notions of power related to vehicles of social division such as race, class, and gender, I discuss the concept of “intersectionality” arriving out of feminist and critical legal scholarship, along with its limitations. I then examine the social science literature on citizenship building to an argument that immigration policies, particularly those that instill fear in immigrants, are an exercise of power to create the model neoliberal citizen: an autonomous agent of the labor force who makes few, if any, demands from the sovereign authority, such as the use of social services. Central to this argument is how Foucauldian scholars conceptualize governmentality. For this chapter and elsewhere in the dissertation, governmentality can be understood as the “techniques of governing,” which can include specific regulation but further incorporates “knowledges, and representations that control populations,” (Butler 2004; Hiemstra 2010: 76) relying on both direct and indirect modes of managing groups of individuals (Hiemstra 2010: 76). Processes of governmentality comprise numerous strategies that “operate diffusely, to dispose and order populations” (Butler 2004: 52). As I describe in this chapter, ordering populations is central to biopolitics and the overall management of life as a population.

**Power**

As this dissertation primarily focuses on power relationships and governmental power applied to a specific population (undocumented immigrants living in Atlanta) it adopts Foucault’s description of power as relational, lacking a single source, and featuring the ability to serve particular agendas. This analytic of power is useful as it specifically throws into view constructs of race that are central to applications of power concerning immigrants. Embracing a
Foucauldian approach to power does not necessarily ignore the political economy of immigration regimes, however, as some scholars critiquing Foucault may suggest (Ortner 1995; Roseberry 2002; Wolf 1990). Recognizing the political economy of transnational labor migration, and noting that several scholars have brought together Marxist and Foucauldian aspects of power (Jessop 2007; Yelvington 1995), I draw from Foucauldian notions of power that recognize the role of racial constructions as well as the political economy of immigrant exploitation.

Several scholars paying attention to race and state power have demonstrated how racial differences and exercises of governmental power can ultimately structure or reinforce capitalist power regimes (Levine 1988; Martin 2008b; Patterson 2009: 141; Poulantzas 1973; Yelvington 1995). Moreover, Marxist scholarship demonstrates how race and governmental power can structure political economy and serve as a mode of domination (Wolf 1990), allowing for relationships of domination mirroring tensions of bourgeoisie and proletariat classes to arise (Clark 2002; Gupta 2002; Lem and Leach 2002). Shifting analytical focus beyond how power may structure political economy, however, allows for examining how power relationships can be used for numerous strategies that are not limited to economic forms of domination. Accordingly, a Foucauldian understanding of power allows for recognizing how governmental power serves political economy aims and further allows for greater exploration of how race and other forms of social division operate beyond economic spheres.

Rather than being a superstructural phenomenon that constructs political economy, Foucault conceptualizes power as relational and without a single source. Power, to Foucault, involves a dynamic and dialogical process, and is not an object to be wielded or a tool used to produce an outcome. “Power is everywhere” (Foucault 1978: 93), Foucault writes, not just in labor relationships, and that there is no single “source” of power:
The idea that there is either located at—or emanating from—a given point something which is a ‘power’ seems to me to be based on a misguided analysis, one which at all events fails to account for a considerable number of phenomena. In reality power means relations, a more-or-less organized, hierarchical, co-ordinated cluster of relations” (Foucault 1980: 199)

Even in hierarchical settings like factories or the army, Foucault argues that those at the top of the hierarchy are not the source of power: “The summit and the lower elements of the hierarchy stand in a relationship of mutual support and conditioning, a mutual ‘hold’”…(Foucault 1980: 159). Power is therefore not an invention or a tool, nor is it a binary relationship of dominators and dominated, but instead a relational process (Foucault 1980: 142). This is not to suggest that power relationships cannot serve specific agendas, however. On the contrary, Foucault clearly articulates that power relationships can be used for specific strategies, such as accumulating capital: “power relations do indeed ‘serve’, but not at all because they are ‘in the service of’ an economic interest taken as primary, rather because they are capable of being utilized in strategies” (Foucault 1980: 142). Foucault thus demonstrates an ability to examine how power shapes labor and economy, whereas Marxist notions of power suggest power relationships are produced by labor and material relationships. Rather than limiting analysis to labor and economy, Foucault offers that notions of power can be used to assess multiple social relationships. This is particularly important because some scholars have questioned the utility of historical materialism in settings where labor relationships are not characterized by previously relevant categories of industrial worker and owner/controller of means production (Poster 1984). Foucault’s conceptualization of power as relational, having no single source, and having potential to be used for specific strategies allows for understanding
power as a “cluster of relations.” allowing for “a grid of analysis which makes possible an analytic of relations of power” (Foucault 1980: 199).

A Foucauldian perspective of power that is not focused on superstructural materialist ideals allows for examining power interactions that are based on social categories intersecting with and compounding class and production, such as race, gender, and sexual identity. Foucault’s conceptualization of power is additionally useful because it allows for exploring how power operates in social organizations, institutions, and among individuals, rather than being limited to examining how power structures labor relationships and social class differentials. Moreover, without being confined by a superstructural understanding of power, it is possible to examine how power operates and is dispersed through multiple social levels. Of particular interest is how Foucault describes power over populations, or “biopower:” power over life (Foucault 1978: 140). Foucault argues that mechanisms of power have changed significantly since the seventeenth century and have transformed their focus from death to investing in life (Foucault 1978).

**Biopower**

Describing how power over life was once exercised as a deductive force by the sovereign who deciding matters of life and death and mechanisms of subtraction through taxation, Foucault argues that power mechanisms transformed into two different but connected forms around the seventeenth and eighteenth centuries (Foucault 1978). Together, new exercises of power, Foucault argues, were designed to “incite, reinforce, control, monitor, optimize, and organize the forces under it: a power bent on generating forces, making them grow, and ordering them, rather than one dedicated to impeding them, making them submit, or destroying them” (Foucault 1978: 136). This new form of power, Foucault writes, further “endeavors to administer, optimize and
multiply [life], subjecting it to precise controls and comprehensive regulations” (Foucault 1978: 137). Power thus became invested in life and regulating life, and more specifically, power over life, Foucault argues, became characterized by two linked together “poles:” disciplines, which he described as an “anatomo-politics of human body” (Foucault 1978: 139) and “regulatory controls: a biopolitics of the population” (Foucault 1978: 139). The emergence of the two poles of power, disciplinarity and biopolitics, marked a change in technologies of power—techniques, or applications of power—“characteriz[ing] a power whose highest function was perhaps no longer to kill, but to invest life through and through” (Foucault 1978: 139). These technologies of power also made possible the optimization of life for capitalist economic production without making government more difficult (Foucault 1978: 140-141).

Disciplinary power, the first of the bipolar power mechanism to emerge in the seventeenth century, conceptualized the body as a machine, which made possible “its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, [and] its integration into systems of efficient and economic controls” (Foucault 1978: 139). Disciplining bodies occurred through institutions like

---

16 This does not mean Foucault does not allow for understanding the biopolitics of death, however.

17 While Marxist scholarship may focus on how power structures political economy, Foucault instead insists that the development of capitalism occurred as a result of the way in which power changed; capitalism was made possible because of biopower, but biopower also allowed for other social phenomena to develop. Moreover, it should be noted that the techniques of power Foucault describes were not explicit designs of sovereign power. He argues that there was no individual or set of individuals devising systems of power to further their own interests, but instead “these tactics were invented and organized from the starting points of local conditions and particular need,” which “took shape in a piecemeal fashion, prior to any class strategy designed to weld them into vast, coherent ensembles” (Foucault 1980: 159). This assertion that techniques of power can develop without a controlling figure directly conflicts with dialectical power models that assume relationships of dominance with specific agents or actors who devise systems of power.
universities, schools, hospitals, and army barracks, all of which create organized systems of education and apprenticeship (Foucault 1978: 140). The body thus became an “object and target of power,” acted upon to increase its docility and usefulness (Foucault 1977 [1995]: 136). Disciplines were thus the methods that “made possible meticulous control of the operation of the body, which assured the constant subjection of its forces and imposed upon them a relation of docility-utility” (Foucault 1977 [1995]: 137). Disciplines are not identical with the institutions in which they are found, however, and Foucault notes that disciplines should be thought of as a technology of power (Foucault 1977 [1995]: 22)—a form of power that operates on bodies in an effort to make bodies do something and function over time “in prescribed ways or at prescribed levels” (McWhorter 2009: 46). Disciplines of the body were thus a form of power that targeted individuals and individual regulation.

The second pole of power to emerge, regulatory controls, developed in the 18th century and departed from disciplines and anatomo-politics by focusing on the body as a species, “imbued with the mechanics of life and serving as the basis of the biological processes: propagation, births and mortality, the level of health, life expectancy and longevity, with all the conditions that can cause these to vary” (Foucault 1978: 139). Whereas disciplinary power focused on individual bodies, regulatory controls focused on groups of bodies—the species of humanity and human beings as populations rather than individuals (Foucault 1978: 140; Foucault 2003: 242). The emergence of this new technology of power that focused on humans as a species rather than anatomo-politics of individual human bodies represents the beginning of biopolitics—management of the human “race” (Foucault 2003: 242). Biopolitics can thus be understood as the pole of power focused on administrating populations, or groups of bodies and overseeing their “vital” characteristics related to life, such as morbidity, endemic and epidemic
disease, mortality, birth rates, health status, and fertility (Foucault 2003; Rose 2007: 54).

Biopolitics works in concert with disciplinary power, however, as regulatory controls targeting populations allowed for calculated methods relating to the institutions that operate on the body specifically (Foucault 1977 [1995]: 136; 140).

Connections between biopolitics and anatomo-politics are best seen in institutions managing life, such as medicine, and when examining the foundation of contemporary disciplines concerned with population surveillance such as demography and public health. Public health, in particular, is located at the very foundation of biopolitics—keeping populations alive, which can be seen in the heart of epidemiology and current governmental practices shaped by vital population statistics. Power thus transformed from being the “right of the sword” of the sovereign (Foucault 2003), or the right to kill, to the right to keep alive, to manage life and regulate it. Accordingly, biopolitics takes shape in the management of cities and space, town planning, and administering of health services (Rose 2007: 54). As Rose writes, biopolitics has been “inextricably bound up with the rise of the life sciences, the human sciences, clinical medicine. It has given birth to techniques, technologies, experts, and apparatuses for the care and administration of the life of each and of all…” (Rose 2007: 54). Administering life includes the way that it is managed between human beings, and biopolitics includes efforts to control relationships between people, their environments, and the context in which they live (Foucault 2003: 245). Biopolitical mechanisms thus examine the politics of the population and devise interventions of generality instead of specificity that target individuals (Foucault 2003: 246)(emphasis added). Rather than training individuals and bodies like disciplinary techniques do, biopolitics instead works on the human species in order to regularize rather than discipline (Foucault 2003: 247). Regulation of and investment in life, however, leaves room for power and
regulating death, and Foucault argues it is the regulation of death where race and racism as a regulatory mechanism becomes important.

Racism, as Foucault identifies, is a process of separating groups within a population for fragmentation, hierarchization, determining superiority and inferiority, and otherwise subdividing populations established through biological frames (Foucault 2003: 255). Racism thus as two specific functions: to fragment and to create a biological relationship based on survival and success, which can ultimately justify death through the life and success of another race (Foucault 2003: 255-256). Foucault argues the biologically rationalized racism relationship of life and death informs the justification of racially-motivated war killing and killing “abnormal” and “degenerate” populations, a type of killing that is imperative to the survival of the other race. Racism thus becomes the “precondition that makes killing acceptable” (Foucault 2003: 256). Demonstrating this idea, Foucault describes the Nazi regime as a murderous and racist state that exposes its entire population to a type of death and killing targeting some groups but justifying the survival of others (Foucault 2003). Killing is not simply the act of murder and physical destruction, however, but every type of “indirect murder,” as Foucault describes—a type of political death, expulsion, and rejection (Foucault 2003: 256). This notion of political death emphasizes the importance of race in power constructions.

Racism is therefore a way that biopolitics, a type of power invested in optimizing life of the population, allows for destruction of subdivided groups within a population. This is made possible by themes of evolutionism, which aids in constructing groups of people as biological threats and adversaries and has informed colonialism and war efforts (Foucault 2003) 257). Racism conflated with evolutionism fueled Nazism eugenic arguments for “improving” population health, and more contemporary attempts to “optimize” vital aspects of life on a
molecular level through new biological technologies such as genomic medicine (Rose 2007). As Foucault argues, biopolitics that functions to exercise rights of war and rights of death require a type of racism, and this problem remains unresolved among modern political states (Foucault 2003: 263). The importance of racism and its association with the development of instruments of power also underscores how Foucault considers ways that power can segregate and create social hierarchies which can produce hegemonic effects and relationships of domination (Foucault 1978: 141).

Extending Foucault’s analysis of race and power, Agamben (1995) specifically indicts sovereign power in his formulation of biopolitics, arguing that “the production of a biopolitical body is the original activity of sovereign power” (Agamben 1995: 11). Building upon Foucault’s notion of political death, and following Foucault’s argument that life and politics are inseparable, Agamben, invoking Arendt (Arendt 1973), asserts that sovereign power is behind biopolitical processes, a contention Foucault outwardly rejects. Beyond acknowledging potential for death in biopolitical arrangements, Agamben emphasizes the role of death in biopolitics and argues that the sovereign links power to life so that it can make political use out of the death of its subjects (Rose 2007: 57). Drawing from a figure in ancient Roman law known as the *homo sacer*, Agamben argues that the sovereign had the authority to kill and to reduce a person to a depoliticized version of life he called bare life, or *zoē*. The concentration camp and destructive horrors of the Holocaust, Agamben argues, is an example of sovereign power reducing groups of people to bare life, justifying their destruction (Agamben 1995: 83). Agamben adds that his work on biopolitics should be understood as “thanatopolitics:” the extreme form of biopolitics as they relate to deciding the value and usefulness of life (Coleman and Grove 2009). Thanatopolitics is becoming the biopolitical norm according to Agamben, as the line between biopolitics and
thanatopolitics becomes more eroded and sovereign authority becomes more involved in realms of life, ultimately deciding who lives and who dies (Agamben 1995: 72). Pointing to Nazi Germany as a “radically biopolitical state,” Agamben uses euthanasia programs, laws targeting Jews, and death-camp practices to emphasize how the sovereign, in this case Adolph Hitler, directly decides political utility of populations and determines who is and is not worthy of living (Agamben 1995: 83).

Agamben’s death-focused account of biopolitics sharply contrasts with Foucault, who argues that biopolitics is a form of power “invested in life through and through” (Foucault 1978: 139) to ensure life flourishes, in addition to regulating it. This is not to suggest Foucault’s understanding of power has no accounting for death. On the contrary, in discussing racism made possible through biopolitics, Foucault discusses the destructive potential of biopolitics and governmental power, using Nazi-inspired genocide as an example, much like Agamben does. Unlike Agamben, however, Foucault allows for the possibility of a type of power invested in life to justify destruction of another, whereas Agamben instead emphasizes biopolitics as destruction and death. This emphasis downplays the relationship behind death and the pressing questions of what purpose (political or otherwise) does the death serve, who does it benefit, and why is it considered necessary or politically expedient?

Thus, thanatopolitics, the death-focused form of biopolitics whereby the sovereign directly decides who to let live and who to let die, is problematic for two reasons. First, the concept overemphasizes the point of death so much that the relationships between those deemed worthy of death and those deciding the death gets lost and thus cannot be adequately assessed for larger political meanings. This conceptualization of power therefore minimizes the possibility for power to be a relational process diffused across numerous sites, including everyday spaces of life.
such as schools, neighborhoods, and workplaces. Secondly, thanatopolitics fails to account for resistances to power; under Agamben’s framework, power as an exercise of the sovereign cannot be resisted, questioned, or changed, but power is ultimately exercised to commission death. Indeed, Agamben’s work on thanatopolitics would lead everyone to assume that power relationships are analogous to a hyperbolic dictatorship, whereby the sovereign authority has absolute rule over life and can unilaterally decide outcomes over all situations (Rose 2001). This is because of the ahistorical nature of Agamben’s assessment of biopolitics. Whereas Foucault discusses the way exercises of power changed over time to increasingly focus on life and bodies, Agamben asserts that life has always been a political focus since the inception of the polity (Blencowe 2010). This notion of biopolitics as an ancient creation dehistoricizes biopolitical endeavors, and as a result, leaves little room to understand similarities and differences of biopolitical constructions such as race and how they operate in different places (Smith 2010a).

Thanatopolitics is therefore too narrow of an understanding of biopower for the purposes of this study but deserves attention for the way in which Agamben implicates the state in destructive attributes of biopolitics. Nevertheless, exercises of biopower have historical and geographic roots that operate in historically and geographically unique ways. Not all contemporary exercises of biopower are linked to threat of death by the sovereign, and the concentration camp, according to Foucault (2003), represented an extreme form of biopower that occurred within a dictatorship (Rose 2001: 201). While some moments can justify states of exception, such as humanitarian crises (Fassin and Vasquez 2005), the state of exception that creates the homo sacer is not necessarily the norm (Rose 2007: 58). Moreover, Foucault’s relational account of biopolitics is important when examining undocumented immigration in the United States since immigrants’ “illegality” has become a relatively new racialized category (as I
discuss in more detail later in this chapter) justifying certain biopolitical actions that may prompt specific forms of resistance.

**Biopolitics and Vehicles of Social Division**

In describing biopolitics as a pole of power focused on administering and overseeing entire populations, Foucault describes instruments of power to manage groups of people that have resulted in social hierarchization and relationships of domination and hegemony (Foucault 1978: 141). These relationship-structuring instruments of power include race, sex, nationality, and social class, all of which serve as vehicles of division to maintain a white, male, heterosexual, dominant power regime. Each of these vehicles of division are relevant in discussing undocumented immigration because they show how nationality and immigrant “illegality” are also forms of social division that play a role in constructing immigrants as undeserving of social services and as targets of specific forms of legislation aimed at constructing them as a type of neoliberal citizen.

Race has historically been a tool of social division used in the service of biopolitical aims. At its most basic level, race involves constructing who belongs and does not belong to a specific group, and accordingly, who receives or is denied rights associated with specific groups. These rights can include life itself, as Foucault emphasizes by describing how racism can adopt biologized rationales for eugenics and genocide. In the United States, race as a biologically-reasoned social construct has been an important aspect in defining “white” populations and separating them from nonwhite populations. Earlier in this chapter I note that power relationships, according to Foucault, can be used to serve a specific strategy. In this section, I describe how race is such a power relationship that has changed over time, been used strategically as a political tool, and has been normalized through disciplinary techniques. Race is a technique of power that
allows power operations to work (Foucault 2003): “Biopower can’t function without racism and modern racism takes shape within the forces of biopolitical function and expansion” (McWhorter 2009: 58). Following Sheth, I assert that race is a “mode or vehicle of division, separation, hierarchy, exploitation, rather than a descriptive modifier” (Sheth 2009: 4) that serves to manage populations and society in general (Sheth 2009: 22), thereby making race a form of biopolitical governmentality (Foucault 2003; Rasmussen 2011). Race is not the only vehicle of division, however, as I describe later, noting that techniques to manage populations interact with one another.

Race has been conceptualized differently depending on historical context and has been used to challenge or maintain power structures. For example, race, conceptualized as lineage in seventeenth-century England was used to organize warfare and challenge the sovereign authority of Norman rulers over Saxons (McWhorter 2004: 48-49). This notion of race underscores how “race war discourse was invented by an oppressed group to consolidate its membership and harden them against their oppressors. It enabled the production of a counter-history that served to reify and rally a people for revolution” (McWhorter 2009: 58). Over time, however, race “transformed from a tool of the underclass to a tool of the bourgeoisie,” and eventually became translated into biological categories (McWhorter 2009: 59).

In her genealogy of modern racism in the United States, McWhorter notes that race first became a tool of the wealthy elite in the 1600s when wealthy landowners made efforts to destroy solidarity between European- and African-descent laborers (2009: 72). As a result, race transformed from a notion of lineage to one of morphology in an effort to “drive a legal and psychological wedge between laborers of African and European descent…”(McWhorter 2009: 72). Tobacco colony governments deliberately lowered the legal status of African-descent
laborers and elevated the status of European-descent laborers to create inequality in the labor force and incite interpersonal conflict in an effort to get European descendants to support the continuation of slavery (McWhorter 2009: 72). Over time, race transformed from a concept based on morphology to biological difference.

With the advent of biology as a life science in the early 1800s, race became a way to answer questions related to the biological development of human beings as a species and “civilization” (McWhorter 2004: 51). For early biologists, white, European society represented the pinnacle of society and biological development of human beings, with Native Americans and “bushmen” of Africa occupying the lowest level of development for the species (McWhorter 2004: 51). As McWhorter notes, biology was crucial in the process of solidifying race as a concept and as a social gradient:

Thus was biology a major force in the creation of the concept of race as graded type. Superior and inferior human types—races—became biological facts. Biologists then set out to make sense of those facts. Data on morphological groups were amassed and norms of development were established. Races were ranked according to how developed, meaning how civilized, their representatives were thought to be (2004:51).

This biological “transcription” of race, as Foucault states, ultimately gave rise to operations of power that maneuver in ways to assure one race holds power and protects itself from “those who pose a threat to the biological heritage” (Foucault 2003: 61). Preoccupations with race and notions of protecting one race from inferior others informed the eugenics movement the Nazi party platform, sterilization campaigns, anti-miscegenation laws, and marriage restrictions (Agamben 1995; McWhorter 2004; McWhorter 2009). The biological acceptance of race as a tool for social division has most recently been revived through efforts to mark race as genetic difference, leading to the development of race-based medical interventions
that further reinforce race as a relevant and biologically-driven category (Roberts 2010). Furthermore, the biological transcription of race was a process of a disciplinary system engaging in normalization—creating a set of rules, standards, and norms by which to judge the abnormal: that which does not fit within the framework established by the normalization processes (McWhorter 2009: 52). This normalizing power also extended into other areas of life, such as sex and gender.

As mutually dependent and normalizing forces to regulate populations (McWhorter 2009: 14), race and sex have the same genealogy and have arisen within the same assumptions about life and governing (2004: 39). The notion of sex ties together the bipolar mechanism of power comprising disciplines of the body and technologies of regulating populations (Foucault 1978: 145; Stoler 1995). As Foucault explains, “Sex was a means of access both to the life of the body and the life of the species. It was employed as a standard for the disciplines as a basis for regulations” (Foucault 1978: 146). As a concept, sex became a principle for how space was ordered, informed medical and psychological examinations, and gave rise to statistical methods of assessments and interventions that targeted entire populations (Foucault 1978: 146).

Furthermore, sex became a critical component for managing life (Foucault 1978: 147), leading to specific bodily regulations such as prohibiting masturbation and gendered expectations. The hysterization of women, for example, occurred as part of gendered expectations for women to care for the health of their children ensure the solidity of the family institution (Foucault 1978: 146-147).

Just as race gained biological legitimacy, so did gender and sexual identity when medical researchers in the late nineteenth century began conducting studies on sexual maturity and activity. When researchers observed deviations from what they perceived to be the norm, they
recorded and began categorizing the deviations, which included fetishists, auto-monosexualists, and homosexuals (McWhorter 2004: 45). People who fit into these categories were considered to be developmentally inferior and fixed in a position along a developmental trajectory, which identified heterosexuality as the point of full development. The sexual-development trajectory mirrors the racial hierarchies and developmental theories of 19th-century biologists. Some biologists argued that inferior sexual development would result in total degradation of the person, and anyone who was developmentally flawed should not reproduce and consequently produce more “degenerates” among the population (McWhorter 2004: 45). This rationale led some US states to adopt forced sterilization policies for homosexuals in the early 20th century (Greenberg 1988), not unlike the eugenically driven sterilizations that also occurred in an effort to protect the health of “the white race” (McWhorter 2009).

Sex and race thus arrived from the same set of normalizing techniques that have made the socially-created phenomena seem biologically derived. Just like race, sex and sexual identities emerged as a result of normalizing techniques and placing the concepts within a trajectory of biological development. When sex and sexuality appeared as concepts in the 1800s, they entailed numerous conflated biological and social processes, including behaviors, biological functions, and anatomy (Foucault 1978; McWhorter 2004). Moreover, sex and sexuality ultimately became conflated with gender, a set of behaviors associated with each sex (McWhorter 2004) that further contributed to normalization processes surrounding sex and gender. Normalizing whiteness and heterosexuality through the creation of race and sex ultimately served to uphold white, heterosexual power structures, driving eugenic efforts to rid the human race of deficiencies that singled out nonwhite, non-heterosexual, and non gender-conformist populations seen as a threat.
to society and to the biopolitical order (McWhorter 2009). The biological inscription of race and sex have made the concepts effective divisive tools.

Because race in particular is a powerful tool of division (McWhorter 2009: 60), the lasting effects of race have been resounding. In the United States, race has had lasting effects on disproportionate wealth accumulation, access to housing, higher education, health outcomes, and ability to live in communities free from environmental hazards (Bullard 1990; Bullard 1993; Bullard 1999; Checker 2005; Conley 1999; David and Collins 1997; David and James Collins 2007; Kawachi et al. 2005; Moberg 2002; Mott 1995; Pulido 2000; Shapiro 2006). Moreover, because of the way in which race has become biologically transcribed, it is considered axiomatic, making it an insidious form of division that seems “natural.”

The axiomatic element of race has been instrumental to its critical exploration, as numerous scholars have sought to understand how notions of race uphold a power structure that benefits white populations. Critical race theory, arising from legal scholarship in the United States, emerged to explore how race plays a central part in organizing society and to understand how “a regime of white supremacy and its subordination of people of color have been created and maintained in America, and, in particular, to examine the relationship between that social structure and professed ideals such as ‘the rule of law’ and ‘equal protection’”(Crenshaw et al. 1995: xiii). Moreover, critical race theory offers a lens through which to understand how the U.S. legal system supports white dominance (Bell 1995a; Bell 1995b; Delgado 1995; Freeman 1995), which is particularly important in assessing how immigration policies play a role in perpetuating undocumented immigrants’ social inequalities. Critical race scholars, along with other feminist scholars of color, have pointed to how race and the structures supporting race ultimately uphold a power regime benefiting white populations, and additionally draw attention to how race, gender,
and social class “intersect” to produce compounded inequalities (Collins 1999; Collins 1998; Crenshaw 1995; hooks 1981; Roberts 1991; Roberts 2011). Intersectionality, coined by Crenshaw (Crenshaw 1991; 1995) dismisses one-dimensional ideas of inequality to focus on particularities of discrimination. This allows, for example, ways of assessing how black women’s experiences are shaped by racism and patriarchy in ways that black men’s experiences are not (Brown 2012).

Intersectionality allows for examining how race, class, and gender provide profoundly different opportunities and shape multiple experiences based on varying dimensions of otherness that intensify one another. This analysis allows for understanding how, for example, policies such as the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) reproduce ways of viewing black women in ways that uphold white hegemony and assert black women’s deviance, inferiority, or subordinate social position to serve white power structures (Neubeck and Cazenave 2001: 4; Roberts 2011). Understanding intersections of differing forms of discrimination can point to different biopolitical mechanisms, demonstrating how disciplinary techniques to manage entire populations can intersect and produce different experiences for populations occupying more than one category being managed. Intersectionality thus offers ways to examine how some populations are subordinated in an effort to uphold the power of another group, not unlike the way Foucault describes the way racism operates to justify forms of “political killings” for one group so that another group may succeed. Race as a form of social division thus allows for differential forms of success and opportunities to benefit some groups over others.
Racialization of Nationality

Further highlighting how race is a vehicle of division and serves specific political purposes, US immigration policy underscores the way in which nationality became racialized, as people from “undesirable” races and nations were systemically denied entry or expelled from the United States (Kretsedemas and Brotherton 2004; Ngai 2004). Sarah Horton (2004), for example, has shown how of race and nationality can impact immigrants’ reception into the United States, noting that Cuban immigrants who are associated with qualities more closely aligned to “whiteness” than other immigrants such as Mexicans, are better received once they immigrate. Similarly, Aiwha Ong (1995; Ong 1996) describes how Chinese immigrants are associated with qualities of “whiteness” such as an entrepreneurial drive that makes them better received in the US than other Asian immigrants such as Cambodians. Differential treatment of immigrants based on race has a deep history in the US; race-based immigration quotas created in the early 20th century established “a global racial and national hierarchy that favored some immigrants over others” (Ngai 2004: 3). This process, the national-origins system, created quotas for European countries but designated all Europeans as part of the white race separate from nonwhites. The national-origins systems also excluded some immigrants such as Chinese, Japanese, Indians, and other Asians from immigrating because their race made them ineligible for citizenship (Ngai 2004: 7). Race-based quotas were partly informed by eugenicists’ reports of potential “degradation to the white race” (Ngai 2004: 24), demonstrating the racial motivations for immigration restrictions. Although eugenic ideas may no longer inform immigration policies, racial ideas continue to influence immigration practices. More recently, racialized policies have taken aim at Arab-Muslims, leading to the racialization of terror suspects following the events of September 11, 2001. This has resulted in the deportation of hundreds of Arab-Muslim men from
the United States, despite never being charged for conspiring to engage in terrorism in an effort to appear as if progress was being made on the “war on terror” (Sheikh 2004). Policies targeting Arab-Muslim immigrants have had enduring consequences, as some evidence suggests that anti-Muslim violence and hate speech have increased in the past decade (Kretsedemas and Brotherton 2004: 11).

US immigration practices of exclusion and removal, like the immigration quotas of the 19th century, the passage of the Chinese Exclusion Act, and deportation of Arab-Muslim men, exemplify a form of state racism through the process of classifying and opposing a population based on categories of origin (Foucault 2003: 63; Tyler 2010). Further underscoring how immigration policies are entangled with ideas about race and who makes ideal racial citizens for the nation-state (Ngai 2004: 3), recent policies differentiating “legal” from “illegal” immigrant demonstrate how illegality has become a racialized category (Chavez 2007; Coutin 2003; Coutin 2005b; De Genova 2004; Heyman 2008; Hiemstra 2010; Willen 2007a; Willen 2007b). The term “illegal alien” in particular is “associated with racism towards Mexicans and other Latinos and Latinas” (Ngai 2004). Immigrant illegality surrounds notions of race that effectively criminalize all “brown bodies” (Hiemstra 2010: 79), and the term “illegal alien” carries implicit assumptions about criminality and social deviance that justify measures of criminalization in an effort to “protect” the broader population. This is highlighted by the large number of immigrants held in federal custody: noncitizens are almost one third of the federal prison population (despite accounting for only 13% of the entire US population) and immigration violations remain a focus for the federal government (Kretsedemas and Brotherton 2004: 4; Migration Policy Institute 2014). Indeed, immigrant “illegality” is more than a juridical and political status; it further encompasses sociopolitical conditions such as racialization and criminality, shaping everyday
experiences for undocumented populations (Hiemstra 2010; Willen 2007b), such as being denied access to social services. As Dorothy Roberts argues, conflating race and criminality impacts myriad life chances and assumed criminality of non-white populations promotes racist notions of non-whites being undeserving of full sets of rights and entitlements accompanied with national citizenship (Roberts 2007: 264-266; Uggen and Manza 2002).

Figure 1: With GLAHRiadores outside of Stewart Detention Center, a facility where immigrants are detained until they are deported.

Deservingness as a Form of Racism

Racializing nationality and the way in which race acts as a vehicle of division allows for perpetuating differential set of rights and entitlements for immigrants in the United States along with a differential conceptualization of deservingness to social services, including health care. Several medical anthropologists have recently turned their attention to the way in which a population is considered “deserving” or “undeserving” of health care (Castañeda 2012; Chavez 2011; Gottlieb et al. 2012; Horton 2004; Larchanché 2012; Marrow 2012; Viladrich 2012;
Wailoo et al. 2006; Willen 2012b), highlighting how deservingness hinges on juridical, political, and local discourses about specific populations (Willen 2011b). Notions of deservingness should not be confused with entitlements or access to health services, as Willen (2012a) cautions; instead, deservingness can be seen as a logic of exclusion. In the US, many immigrants are not permitted the same access to safety net social services as US citizens and are not seen as deserving of some services such as health care. Adding to the growing scholarship of deservingness, I assert that deservingness is a biopolitical category influenced by political economic factors and a specific type of state racism that can allow for physical or political death Foucault describes, best exemplified through how vulnerable populations such as undocumented immigrants are conceptualized as undeserving of social services.

Undocumented immigrants are particularly susceptible to logics of undeservingness in the United States. Concepts of undeservingness center on immigrants’ exclusion from a political community and from a moral community as their concerns and needs are considered unworthy of attention (Fassin 2009; Willen 2011a; Willen 2012a). Over time, notions of deservingness can have “embodied” consequences, epidemiologically and phenomenologically (Willen 2012a: 806), as undocumented populations go without regular health care and in some cases begin to consider themselves “socially illegitimate” (Fassin 2004). In the United States, deservingness has been a part of the public discourse on unauthorized immigrants’ rights to health or to continue living, as highlighted in the Jesica Santillan story. The death of seventeen-year-old Jesica Santillan, an undocumented immigrant who died in 2003 after Duke University Medical Center surgical staff failed to ensure that the donated heart and lung transplants matched Santillan’s blood type, sparked numerous conversations about immigrants’ deservingness to health services, particularly to organ transplants and other scarce medical commodities (Wailoo et al. 2006). The issue of
organ transplantation demonstrates the extreme lengths the logic of undeservingness travels, so much so that it can include ideas about rights to life. In this respect, racialization of nationality and concomitant logics of deservingness highlight how race is a vehicle of division that justifies unequal treatment, especially in areas regarding health in a market-based medical system.

Racializing immigrants’ illegality can “kill” populations in literal and figurative terms and be justified since biopolitical racism establishes one group as a threat, or in some cases as unworthy of specific interventions. In addition to establishing one group as a threat, biopolitical racism establishes another group that must protect itself against the threat or justify the destruction of a group by promoting the survival of the other (Foucault 2003). This logic undergirds rationales for differential social benefits and perpetuating inequalities that persist in arenas such as health care. The criminalization of undocumented immigrants concomitant with the racialization of immigrant illegality demonstrates this very phenomenon, as undocumented immigrants are considered undeserving of specific sets of rights and entitlements and considered worthy of a political and social death to benefit the non-immigrant or legal immigrant population. When exploring immigrants’ deservingness through the lens of racism, it becomes clear that deservingness is a way of articulating state-based racism and identifying one of its underlying logics. Just as racial difference became something considered axiomatic, so has to some degree deservingness, as it provides an additional layer of difference to justify a state-based racism disguising itself through rationales such as cost and citizenship based political economy that suggests only taxpaying citizens “deserve” health services.

Conceptualizations of deservingness are thus driven by biopolitical technologies such as race but take on new meanings and become their own tools of separation populations. Deservingness is thus a biopolitical tool rationalized, accepted, and justified as an additional tool
of dividing populations ultimately to preserve the racial hegemony of one group over another. As such, deservingness is a form of state racism as it supports efforts to maintain whiteness and cast non-white immigrants constructed as criminal, racial others as being undeserving of social services granted to other populations. Deservingness to social services, however, calls into question immigrants’ relationship with governmental authority, requiring consideration of notions of citizenship and concomitant expectations and benefits.

In the next section I review citizenship literature as a background to advance my argument that race as a biopolitical technology of power, and expressed through the concept of illegality, allows for undocumented immigrants to be fashioned into ideal neoliberal citizens that do not make demands upon the state or utilize social services subsidized by the state.

**Citizenship**

Just as biopolitics offers a useful way to examine relationships of power and managing populations, so do theories of citizenship, which effectively combine individualized disciplinary power and population-based biopolitics under a single analytical framework. Although commonly associated with national identity and belonging to a nation state, the notion of citizenship can describe how populations struggle and make claims for political, social, and economic recognition, and frame ideas about rights and obligations (Isin and Turner 2002). Citizenship is not synonymous with “rights struggle,” “inclusion,” or “belonging,” however, because these terms fail to capture the power relationship between multiple groups of individuals and the sovereign power. Whereas citizenship was once narrowly defined as “the legal relationship between the individual and the polity” (Sassen 2002: 278), it can be understood as a relationship between the individual, a group of individuals, the polity, and other actors entangled in a network of power relationships. This relationship is not unlike the notion of biopower
Foucault describes, which encompasses power relationships and ways of ordering populations and managing individuals. I argue that the concept of citizenship builds upon the foundations of biopower that consider anatomo-politics and biopolitics as techniques of power, and emphasizes considerations of rights and responsibilities for those deemed citizens and non-citizens. Citizens can therefore be populations acted upon, much like the way biopolitics concerns populations, or can be individuals who act in specific ways in relationship to constructions of citizenship—mirroring how individuals can resist disciplinary regimes associated with anatomo-politics.

Citizenship as a concept merits anthropological inquiry because it is increasingly relevant in understanding issues surrounding transnational migration, labor exploitation, gender, class, and race, and of other logics of exclusion (Kipnis 2004: 255). Moreover, citizenship theories can describe power relationships that encompass biopolitical and anatomo-political domains, documenting the ways in which populations resist citizenship projects (biopolitical power operations) or assert claims to specific forms of citizenship (anatomo-politics and a resistance of biopolitical constructions of citizenship). In examining power relationships, citizenship theories are also appropriate for examining power between populations and governments; Rose and Novas, for example, describe citizenship in relation to ‘citizenship projects:’ the way in which “authorities thought about (some) individuals as potential citizens, and the ways they tried to act upon them” (2005: 339). Citizenship theories thus echo Foucauldian notions of power as relational and involving potential for governing individuals and populations.

Recent anthropological work on citizenship especially emphasizes the anatomo-political potential of citizenship as an analytical concept, highlighting how vulnerable populations may draw on their biology and tales of suffering to assert citizenship claims and rights to social services, health care, and biomedical technologies (Biehl 2007; Ecks 2005; Nguyen 2008;
Petryna 2002; Petryna 2004; Rose and Novas 2005). Citizenship scholarship has also highlighted how citizenship claims can be used to resist biopolitical control based on gender or sexual orientation (Lister 2002), and how logics of exclusion may influence distributive medical practices (Castañeda 2007; Schep...
therefore allows for combining biopolitical, population-based assertions of power with individual impacts of citizenship constructions, such as being denied health services, having limited mobility, and a range of other impacts.

With an ability to effectively discuss the individual impacts of biopolitical endeavors targeting populations, citizenship scholarship can capture large-scale power relationships while simultaneously understanding agentive processes of resistance, but some anthropological work on citizenship focuses more on agentive process and meaning creation. This is especially true in the work of Didier Fassin, for example, whose work on “biolegitimacy” builds upon Petryna’s biological citizenship (Petryna 2002; Petryna 2004) to trace how some populations use their biological suffering to make demands for treatment and how they construct meaning to the values of life. Fassin states that biolegitimacy emphasizes “the construction of the meaning and values of life instead of the exercise of forces and strategies to control it” (Fassin 2009: 52), but makes no argument for why only the construction of meanings and values warrants analysis without simultaneously understanding the forces that try to control life. Moreover, Fassin’s biolegitimacy undoes the very strength of citizenship as an analytic—its ability to concisely conceptualize the biopolitical and anatomo-political under one frame that has explicit meanings. By ignoring exercises and strategies to maintain life, Fassin fails to acknowledge that the meanings and values associated with life that a population develops are partially shaped by the disciplines and institutions that manage life. Similarly, Miriam Ticktin’s work, borrowing from Paul Rabinow’s concept of “biosociality” to describe how unauthorized immigrants in France use their bodies “as a flexible resource” to achieve political recognition (Ticktin 2006), lacks thorough discussion of the power processes to which populations respond, and why these processes compel individuals to draw on biology to receive recognition to claims of suffering
and demands for treatment. The disciplinary processes and institutions of normalization Foucault describes would lend themselves well to understanding how citizenship projects are not just created, but sustained, and eventually challenged.

Examining citizenship through a lens of disciplinarity and institutionalization (but not explicitly so), Aihwa Ong (2006) discusses processes that change citizenship experiences, arguing that neoliberalism is a form of governmentality that shapes and reshapes citizenship. Similarly, Hiemstra (Hiemstra 2010) has argued that among undocumented immigrants, neoliberal governmentality is operationalized through notions of “illegality.” In the next section, I describe how racialized policies targeting undocumented immigrants produce fear and ultimately fashion undocumented immigrants into the ideal, autonomous neoliberal citizen characterized by labor dispensability and not making demands on the state.

**Using Fear to Produce the Ideal Neoliberal Citizen**

A great deal of scholarship focuses on neoliberalism’s effects of shrinking state services and promoting discourses of individual responsibility as a form of governmentality to ensure people provide for themselves rather than seek assistance from the state (Harvey 2007; Hyatt 2001; Maskovsky 2000; Schneider 1999; Wacquant 2001b). Neoliberal governmentality also contributes to undocumented immigrants’ citizenship construction in the United States framed around racialized notions of legality. Following Hiemstra (2010), I explore the relationship between illegality and neoliberal governmentality and argue that policies targeting undocumented immigrants serve to fashion undocumented immigrants into an ideal neoliberal citizen through instilling fear in utilizing social services including, but not limited, to healthcare. Ultimately the potential health related impacts of this process may be dire and further serve to solidify the racialized otherness of illegality.
Asserting that neoliberalism is a biopolitical form of governmentality, Ong writes that neoliberalism focuses on individuals as “living resources that may be harnessed and managed by governing regimes,” whose capacities for capital accumulation, self-governance, efficiency, and productivity must be optimized (Ong 2006: 6). Neoliberalism creates self-governing behaviors through two optimizing technologies: technologies of subjectivity, and technologies of subjection. Technologies of subjectivity create processes and structures of self-animation and self-governance in order for citizens to “optimize choices, efficiency, and competitiveness in turbulent market conditions” (Ong 2006: 6). These technologies include adhering to specific health-maintenance practices and developing special skills for the labor market. Technologies of subjection are processes that “differently regulate populations for optimal productivity,” and specific travel restrictions and labor recruitment fall into this specific category (Ong 2006: 6).

Ong’s argument about how neoliberalism shapes citizenship experiences examines the governing aspects of neoliberalism, but notions of individual responsibility and autonomy concomitant with neoliberal economic practices do not shape citizenship projects and experiences by themselves. It is the way in which neoliberalism interacts with biopolitical domains such as race, sex, social class, and national origin to shape the way in which citizens can be constructed and assert their citizenship.

For undocumented immigrants, the racialization of illegality has allowed for policies targeting the undocumented to construct them as the ideal neoliberal citizen: autonomous, independent, and avoidant of seeking services from the state. While increasingly aggressive immigration policies may focus on how the laws are intended to get immigrants to “self-deport” (Kobach 2008), I contend that these policies are a way of using fear as a technology of power in the service of neoliberal governmentality. This type of neoliberal governmentality works to
produce the types of neoliberal bodies that are autonomous, self-governing, and do not rely on social services that may be partially subsidized by the state.

Following increasingly aggressive immigration laws and enforcement practices, many immigrants fear accessing state services such as education and health care, and as a result, their utilization rates of state provided services drops (Calavita 1996b). Following Linda Green’s description of fear as a “chronic condition” embedded in the social fabric among Mayan women in Guatemala (Green 1994), immigrant policing in Atlanta points to a type of fear and insecurity that persists in individuals’ lives and becomes routine. Although Green focuses on overt violence, the situation I describe in Atlanta is a more subtle way of producing a fear response masked through the seemingly neutral and innocuous but formal arena of policy and law. Fear-based governance resulting from immigration policies is therefore a more alarming form of hidden violence that operates more secretly than overt violence.

Despite reducing utilization of social services, undocumented immigrants may continue to work, thus participating in an economic system and choosing (in a coerced fashion) not to access state-supported services. Instilling fear among undocumented immigrants and consequently decreasing their utilization of state provided services underscores how laws that produce fear are technologies of neoliberal governmentality. This must be understood, however, as not merely making immigrants less likely to use social services such as health care or public education; this technology is a way of fashioning the non-citizen into a more ideal body of a productive and autonomous agent who develops a temporary form of citizenship characterized by labor exploitation without protections or benefits provided by the sovereign power. Unauthorized immigrants thus represent the most extreme form of citizenship fashioned by neoliberal governmentality; laborers inserted into the economic apparatus but do not make
service demands of the state. This hyper-exploitative form of citizenship would not be made possible, however, if it were not for the biopolitical processes of race, whereby undocumented immigrants’ illegality is racialized and immigrants themselves occupy a lower social position.

Some may critique this argument by noting that instilling fear among undocumented immigrants may also make them fearful to participate in labor arrangements, thereby undermining the economic goals of neoliberalism. However, this critique focuses solely on economic apparatuses and does not take into account the philosophy of individualism concomitant with neoliberalism. Even if undocumented immigrants are too afraid to participate in the economic system, their fear may make them less willing to seek public assistance from the state (in the form visiting subsidized housing shelters, health clinics, emergency rooms, etc.), and they may instead seek services from within their social networks, such as faith-based organizations. In this respect, undocumented immigrants would still be acting within the idealized framework of neoliberalism as they would be using their own resources to care for themselves, acting autonomously, without aid from the state. Another potential critique is that some undocumented immigrants may still receive benefits from the state, including food assistance and healthcare for citizen children. Indeed, this could be the case, however, children are outside of the purview of discourses of individual responsibility embedded within neoliberal rhetoric because children may be considered the “deserving poor” whereas nonelderly adults facing poverty may be considered “undeserving” (Kiefer 2000).

Using fear as a way to fashion undocumented immigrants as neoliberal citizens shows how their labor is welcomed but their recognition for social membership is ignored. As Ngai writes,
“Undocumented immigrants are at once welcome and unwelcome: they are woven into the economic fabric of the nation, but as labor that is cheap and disposable…marginalized by their position in the lower strata of the workforce and even more so by their exclusion from the polity, illegal aliens might be understood as a caste, unambiguously situated outside the boundaries of formal membership and social legitimacy” (Ngai 2004: 2).

The neoliberal citizen production of Latino immigrants exemplifies the process of differential racialization; the way in which each group of “others” in the United States “has been racialized in its own individual way and according to the needs of the majority group at particular times in history” (Delgado and Stefancic 2012: 77). Indeed, as Hiemstra (2010) has argued, scholars have shown that immigration laws function both to make migrant labor cheap (Bauder 2006; Calavita 2005; Coutin 2005b; De Genova 2005; Mountz et al. 2002) and are simultaneously attempts to manage and characterize populations in a particular way (Chavez 2007), which as I described earlier in this chapter, translates to notions of racialized and criminalized “others.” The criminalization and racialization of immigrant illegality has led to an increasingly dispersed regime of immigration enforcement that enters immigrants’ everyday lives, moving from “the border” into local spaces (Coleman 2007; Winders 2007). In addition to how illegality, neoliberal governmentality, and documenting how immigration policies are respatialized and affect immigrants’ ways of living in specific locales (Hiemstra 2010), medical anthropologists must further examine how these policies affect health and potentially exacerbate existing health disparities on a population level.

**Reinforcing Racialized Notions of Immigrants’ Illegality**

If aggressive immigration legislation and enforcement produce a profound feeling of fear among undocumented immigrants so that they avoid seeking medical treatment in an effort to avoid a harsh immigration regime, then over time, population level health conditions may
worsen for undocumented immigrants. This is alarming not just from a health perspective, but also because of the way that illegality has become racialized; if undocumented immigrants’ health conditions worsen on a population level, then under the current racialized framework of illegality, their worsened health conditions may eventually become understood as an inherent part of their racial category, adding another layer to the “embodied consequences” Willen discusses as part of immigrants’ perceived undeservingness to care.

As noted earlier in this chapter, Foucault writes that power can serve specific agendas, including economic agendas (Foucault 1980). This example of racialization is such an agenda; it was the economic agenda of white plantation owners that helped lay the foundation of contemporary racism in the United States (McWhorter 2009), and the racialization of undocumented immigrants continues to make migrant labor cheap. Creating a group of citizens that does not use social services like health care due to fear ultimately serves an agenda of reserving social services for other groups that occupy higher levels in a racialized social hierarchy, in this case, white men and women. Additionally, over time, denied access to health services for undocumented immigrants may exacerbate existing health inequalities and disparities, and serve to make their socially constructed health disparities seen as inherent to their racialized social category thereby reaffirming their racialized otherness. Critics of this assertion would be appropriate to point to the growing body of literature highlighting that social factors such as poverty play a larger role than race in determining health outcomes (Galea et al. 2011), but that does not change the fact that racial constructions persist, and that over time the lowered health status of undocumented immigrants may serve to reinforce their racialized difference.

In arguing that racialized illegality and policies to instill fear in undocumented immigrants are ways to create a neoliberal citizen who does not make demands on the state I am
not attempting to assert that racialization processes serve political economy and thereby make a Marxist argument after asserting limitations of historical materialism in understanding this research topic. Instead, I assert that the neoliberal citizenship creation can indeed serve political economic aims and also perpetuate the type of race-war construction Foucault describes that allows one population to go without specific resources and is justified by another race receiving those resources. The production of this type of neoliberal citizen who will not make demands on the state therefore not only serves political economic interests but also serves as a way of ensuring hegemonic participation in the very racialization processes creating this phenomenon. By not making demands upon the state, resistance efforts will be diminished and “political killing” can be done more successfully. This effort is resisted, however, as I describe in this dissertation, by immigrant rights organizations who participate in the race-war discourse battle to make demands for specific sets of rights and entitlements.

Conclusion

In this chapter, I have argued that policies targeting undocumented immigrants, especially those that instill fear, are a form of neoliberal governmentality fashioning an ideal neoliberal citizen, which underscores not only a political economic benefit but also the way that race-war discourses can occur. Fear as a form of governance has resulted in undocumented Latino immigrants changing health behaviors and altered family interactions, as I describe in chapters six and seven. These chapters demonstrate how immigrant policing has entered increasingly intimate spaces, made possible through the dispersal of enforcement authority through programs such as 287(g) and Secure Communities. The effects of governing through fear are resisted, however, as I show in subsequent chapters, by groups of immigrants I worked closely with in Atlanta. Moreover, in describing fear as a governing strategy, I aim to show how
immigrant policing that incites feelings of fear is both an exercise of power currently unfolding, as well as a form of power that has had identifiable consequences, such as family separation or avoiding health services at certain cites. Fear-based governance to produce the ideal neoliberal citizen is both a project-in-formation and a project that has already resulted in sets of outcomes felt by some undocumented immigrants living in Atlanta, highlighting how immigrant policing is a vast project with a numerous and far-reaching impacts.

Throughout this chapter I have drawn from Foucault’s notion of biopower as an anatomo-politics of the individual body and biopolitics of the population. This idea of power allows for understanding ideas central to this dissertation because it allows for focusing on how and why populations can be divided through logics such as race and illegality. I have also argued that citizenship scholarship is an effective way of exploring both anatomo-politics and biopolitics, and described deservingness as an articulation of biopolitics and race-war discourse. The race-war discourse, as Foucault describes it, justifies killing one population (physically or politically) because it asserts the strength of another population (Foucault 2003: 258). In the following chapters I expand upon these ideas to demonstrate the impacts of fear as a form of governmentality, the biopolitical domains of end stage renal disease, and forms of resisting immigrant policing.
CHAPTER FOUR:
METHODS AND METHODOLOGICAL FRAMEWORK

Introduction

Immigrant policing efforts resulted in some undocumented immigrants changing their driving habits and how they seek social services, as I describe in subsequent chapters. While living in Atlanta, I often considered the ease with which I could do mundane activities related to driving that some undocumented immigrants feared doing because of the risk associated with encountering a pervasive immigration enforcement regime. Witnessing how undocumented immigrants changed health behaviors, routes to work, their children’s school, and get to the grocery store fueled my motivation to participate in immigrant rights activism. Like many anthropologists who have drawn on activist methodologies to combine academic pursuits with a desire for social change (Davis 2006; Hale 2008; Huschke 2014; Pulido 2008; Sanford 2006; Speed 2006; Stuesse 2010b; Warren 2006), I found myself in the complicated position of activist researcher simultaneously studying applications of political power while participating in the resistance efforts that responded to a form of immigrant governmentality. In this chapter, I describe how activist research methodology contributed to this research and provide an overview of methodological frameworks useful in studying political power.

In the previous chapter, I describe the theoretical lenses appropriate for considering the multilevel impacts of immigration laws, specifically focusing on biopolitics and theories of citizenship. These theoretical perspectives demand methodological frameworks focused on
power and power relationships to adequately explore such relationships. Focusing on policy as a technique of political power, this research uses a multi-sited ethnographic approach to explore the pathways of policy, tracing impacts and opposition to immigration policy and practices that comprise a larger immigration enforcement regime. In addition to exploring policy, I also employ methodologies of social action, drawing from scholarship on activist and engaged anthropology to not only explore power processes from a scholarly point of view, but also participate in one portion of the power process by situating myself within Atlanta’s immigrant rights movement as part of a resistance effort opposing policies targeting undocumented immigrants.

This chapter first outlines the methodological framework for the dissertation, describing key elements of the anthropology of policy, engaged anthropology, and multi-sited ethnography. Ultimately I demonstrate how studying the pathways of political power requires a multi-sited ethnographic approach and describe how engaged anthropology can aid in researching power. After detailing the methodological perspectives informing the data collection activities in this research, I then describe the sources of data and provide an overview of data collection activities and limitations.

**Policy as an Ethnographic Object**

This research began with an interest in understanding how specific immigration laws, such as Georgia’s HB 87, may impact undocumented immigrants’ health. Exploring health-related impacts of immigration laws requires an ethnographic approach focusing broadly on policy. Although there is no specific definition for the term *policy*, it can be used to explain a field of activity (such as “foreign policy”), a specific proposal, or government legislation, programs, or outcomes (Wedel et al. 2005: 35). In this chapter, and elsewhere in the dissertation,
I examine policy related to regimes of authority, specifically focusing on immigration legislation, police practices altering undocumented immigrants’ mobility, and governmental or police actions, official or unofficial, that immigrants I interviewed described as being harmful to their communities. This narrow application of policy is not intended to ignore the breadth of meaning and potential application of the term “policy,” but rather to concentrate on pieces of legislation and specific police practices that act on multiple social levels to shape several outcomes that can have health-related consequences. Similarly, I have chosen to focus on an anthropology of policy rather than an anthropology of the state to maintain focus on legislation and governmental policy that impact undocumented immigrants and as part of an effort to recommend specific policy change. This focus follows Abrams’s suggestion to “move beyond” studying the state and instead study the “tools of social subordination” (Abrams 1988: 63), and I assert that immigration policies and police practices are components of social subordination.

Policy deserves social science attention because, as Shore and Wright (1997) note, “policy has become a major institution of Western and international governance, on a par with other organizing concepts such as ‘family’ and ‘society’” (Shore and Wright 1997: 6). For anthropologists, policy is a particularly relevant field of inquiry because it connects multiple social actors whom occupy different positions of authority in relationships that play a significant role in shaping society (Wedel et al. 2005: 35). Moreover, research exploring ideology—sets of ideas that inspire action, political and otherwise—requires some examination of policy since policy and ideology are “critically linked,” and policy is a “key feature in modern power” (Shore and Wright 1997). Indeed, the relationships between ideology, power, and policy crystalize in places like Georgia where policies targeting immigrants violate specific legal statutes and advance racial ideologies formalized through legislation to constrain the rights of Latino
immigrants. Formalizing ideologies through policy suggests how the way policy can obfuscate inequality and harmful processes targeting entire populations through ostensibly neutral action (Shore and Wright 1997; Wedel et al. 2005). As such, policy can be considered a tool of governmentality and an exercise of power, and an anthropology of policy aims to expose the political elements of policy that are masked in purportedly neutral statements and assumptions about perceived social realities that are driven by ideologies such as race and racial difference (Wedel et al. 2005).

Another governing effect of policy is the production of citizens and norms of ideal citizens. Inherent within policy are classificatory schemes for people and problems that create new populations and categories of people (Wedel et al. 2005). These categories impose ideals of membership, and as Wedel et al. write, “Individuals of a population must contend with, measure up to, subvert, manipulate, or simply internalize these ideal types as part of their own identity” (2005: 37-38). Policy as a governing exercise of power can thus serve to normalize behavior and action (Wedel et al. 2005), or potentially result in acts of resistance. While in Atlanta, I observed incidents when policies targeting immigrants prompted immediate action from immigrant rights organizations. Actions to express resistance to policy included protests, letter-writing campaigns, and visits to local politicians’ and authorities’ offices to demand change. In early 2013, for example, when the Georgia legislature proposed two new laws (SB160 and HB125) that would, among other things, prevent undocumented immigrants from entering federal buildings and obtain utility services for their homes, groups of immigrant rights advocates, including GLAHR, wrote to legislators and held rallies outside the Georgia Capitol to protest the bill.

Resistance activities like rallies responding to specific legislation exemplify how studying policy allows for exploring the role of policy in creating subjects and subjectivities. As
policy produces forms of ideal citizens, and thus can be a “political technology” or “technique of the self” (Wedel et al. 2005) to better govern entire populations, it can create specific subjectivities related to resisting specific policies, such as the activist. In Georgia, the subjectivities of many of the immigrants participating in this research were shaped by an activist identity created in response to policies targeting immigrant populations. The activist identity and associated emotions and actions was not necessarily the only the only subjectivity informed by anti-immigrant policies, however, as I describe in following chapters by discussing how some immigration policies lead to increased feelings of fear and trauma among some undocumented Latino immigrants.

With the ability to examine created subjectivities and governance objectives, the anthropology of policy as a methodology complements theoretical perspectives focusing on power that can shed light on social inequality. For example, a great deal of anthropological research examining policy has focused on growing rates of economic inequality resulting from neoliberal reforms in capitalist economies, demonstrating the way in which policy obscures the application of neoliberal market ideology and results in new forms of governance (Harvey 2007; Hiemstra 2010; Hyatt 2001; Kipnis 2008; Maskovsky 2005; Maskovsky 2006; O'Daniel 2008). Neoliberalism is a shift from Keynesian economic models of government intervention for economic growth stimulation and providing social security, to a less regulated market system and ideally to one that operates in theory without regulation or state intervention. Additionally, neoliberalism entails injecting market ideology into social structures and “involves extending and disseminating market values to all institutions and social action” (Brown 2003; Schwegler 2008: 682). Anthropologists examining how neoliberal policies exacerbate social inequality have explored the way in which neoliberalism is both a form of capitalist market economy and a
method of governance (Shever 2008). Among the numerous anthropologists critiquing neoliberalism through a Marxist perspective, Jean and John Comaroff (2000) succinctly summarize how neoliberalism furthers capitalist agendas by “intensify[ing] the abstractions inherent in capitalism itself: to separate labor power from its human context, to replace society with the market, to build a universe out of aggregated transactions” (2000:305). David Harvey (2007) further adds to Jean and John Comaroff’s analysis by contending that neoliberalism uses rights and freedoms language to obfuscate policies that ultimately result in a dramatic increase in social and wealth inequalities (Harvey 2007; Shever 2008). In contrast to Marxist perspectives, anthropologists examining the way in which neoliberalism has served as a governing technique highlight the way in which neoliberal rhetoric encourages people to govern themselves (Shever 2008) (Hyatt 2001; Maskovsky 2006), particularly by employing strong discourses of individual responsibility.

Anthropological work on neoliberalism, its ability to exacerbate social inequalities rooted in capitalist production, and the way neoliberalism promotes styles of self-governance, point to the utility of employing an anthropology of policy perspective. Although most ethnographies of neoliberalism are not explicitly labeled as an anthropology of policy, they examine the impacts of policy that reveal broader power formations, structures implementing policy, and consequences of specific policy implementation. Studying policy and specific individuals enacting or resisting policy can demonstrate ways that policies are enforced in varying ways, particularly regarding undocumented immigrants. Overlapping domains of government with potentially competing agendas and varying notions of appropriate policy implementation processes has led to policy inconsistencies, as Wells (2004) observes, pointing to local
governments that have restored undocumented im/migrants’ access to social services even when a larger policy context may discourage immigrants from accessing services.

Thus far I have described the need for anthropologists to conduct an anthropology of policy and have argued for the utility of this approach in examining power relationships. An anthropology of policy is appropriate for exploring power relationships, the way in which policy produces specific subjectivities and modes of resistance, and can highlight the way policy can exacerbate social inequality or aid in governance objectives. In addition to the methodological utility of the anthropology of policy, studying policy also has the potential for significant applied contributions. Under the broad domain of “development,” for example, anthropologists have documented the successes and failures of numerous initiatives that have responded to, or created sets of, policy, all of which aimed to bring about successful and meaningful changes for research participants. These efforts include initiatives to reduce health burdens or disease incidence (De Waal and Whiteside 2003; Maternowska 2006), address issues surrounding famine, poverty, and food insecurity (Baro 2006; Braun et al. 1998; Gillespie 2006; Gillespie 2008; Sen 1999; Woodson 1997), promote sustainable or less environmentally-harmful natural resource use (Brosius 1999; Silva 1994), or create microeconomic processes through which some groups can obtain goals such as “cultural preservation” (Deubel 2006). Although some development efforts have been critiqued for arguably applying ethnocentric models of change (Escobar 1991), sustainable, culturally-appropriate models of development demonstrate ways of applying specific policy agendas in careful and thoughtful ways that consider potential negative impacts and attempt to reduce them.

Despite potential for creating policy change, however, not all anthropologists have been successful in creating or challenging policy. Reasons include a lack of recognition or publicizing
of anthropologists’ contributions to policy and poor public communication about policy contributions of anthropological research (Weaver 1985). Limited policy change by anthropologists is in part because anthropologists may not want their non-theoretical work publicized or because the work has only been circulated to a particular agency or institute for which the anthropologist did the work (Weaver 1985). Additionally, anthropologists’ unease with communicating policy applications may be due to the discipline’s past involvement with colonial powers that used anthropological data collection at the center of decision-making processes (Asad 1973; Ben-Ari 1999; Hymes 1974; Lewis 1973; Restrepo and Escobar 2005), underscoring that when made public, anthropological insights are no longer in the researcher’s control.

In spite of the potential dangers, however, an anthropology of policy has the ability to highlight how policy produces or exacerbates inequalities and propose formal ways of addressing disparate social conditions and inspire social action to correct systems of oppression that target vulnerable populations such as undocumented immigrants. The applied contributions of an anthropology of policy can therefore be political and may not take shape as policy briefs or suggestions, but rather a politically engaged and activist informed type of anthropology producing knowledge for those affected by policy to aid in resistance efforts. Policy-inspired activism can focus on how policy is part of a broader system of social inequality that comprises political domains fueled by specific ideologies, such as race, social legitimacy based on national origin or national citizenship, and other forms of social division. During my fieldwork in Atlanta, I participated in policy-inspired or policy-driven activism as part of an engaged approach to understand and respond to the impacts of policies targeting undocumented immigrants in Atlanta. Making policy an ethnographic object allows for researchers to focus on how specific policies
may be detrimental to vulnerable populations and inspire social action. Applied contributions of researching policy are therefore not just potential policy papers or drafted legislation, but also direct political action and activism as an effort to correct social inequality and disproportionate power dynamics.

Engaged Anthropology

Activism within anthropology has developed from anthropologists’ efforts to change unjust social conditions, grapple with unequal power dynamics associated with research, and attempt to better represent informants in ethnography. Anthropology’s “crisis of representation” (Clifford 1983; Denzin 2002; Marcus and Fischer 1999), in particular, compelled anthropologists to not only dispense with “totalizing theory” (Marcus and Fischer 1999) (12), but also address critiques of representing informants, leading some anthropologists to publish only critical, theoretical works, while others tried to find ways to involve and better represent research participants in their work (Speed 2006). During anthropology’s postmodern turn, increased inclusion of participants in ethnographic writing processes and data collection emerged as an effort to balance the power dynamics in research and address concerns over ethnographic representation, but as Warry (1992) notes, postmodern ethnographies overemphasizing concerns of representation in text divert attention from more fundamental issues that may necessitate researcher action (1992: 157). Although textual representation is important, there may be more pressing needs of anthropologists’ marginalized research populations, and anthropologists can use their positions of power to assist the marginalized. Engaged anthropology, and activist research specifically, is one methodology that recognizes unequal power relationships between researcher and informant and aligns the researcher with a political stance that ultimately aims to address disproportionate power dynamics.
At its core, engaged and activist scholarship reject notions of researchers, neutral observers and absolute moral and ethical relativism (Scheper-Hughes 2004). Engaged scholarship expects meaningful contributions to research participants from the researcher, inclusion of participants in each phase of the research, and critical reflection of self and of the research (Hale 2008). Accordingly, engaged scholarship is guided by principles of accountability and reciprocity (Pulido 2008), where the anthropologist is not just an academic, but also a member of a community sharing similar ideals, embracing a self-positioning as a person who is actively part of a social struggle. This perspective arises out of a stance that generating

Figure 2: Holding a sign during a large public demonstration for immigrant rights outside of the Georgia Capitol.
knowledge alone cannot effect social change (Gordon 1991), and as a result, researchers are inserted into a host of relationships with concomitant expectations (Pulido 2008). The emphasis of reciprocity is not exclusive to activist methodologies, but an explicit activist form of research and reciprocal engagement can help produce empirical and theoretical insights otherwise not possible without insider engagement with activist groups (Hale 2008; Juris and Khasnabish 2013; Speed 2008b; Stuesse Forthcoming). Furthermore, reciprocity in engaged research focuses on researchers’ role in providing something in return to their informants, and not just collecting data that ultimately benefit the researcher’s career and do little to benefit the research participants (Pulido 2008). A mutually beneficial relationship, however, should not be summarized as a researcher “giving something back” to his or her research community, which suggests limited reciprocity. Instead, I contend that engaged anthropology entails continued reciprocal arrangements and continued expectations among all actors involved and further entails a common political goal. Furthermore, a political goal is one that confronts and attempts to eliminate inequalities produced through types of otherness including race, class, and gender (Hale 2008). In this research, the common political goal I share with members and leaders of immigrant rights organizations is to end legislation and police practices that interfere with undocumented immigrants’ daily lives, and more broadly, to end systematic discrimination of undocumented Latinos in the United States. Researcher and informant alignment with specific political aims and goals separates engaged anthropology from other methods such as community-based participation research or non-engaged applied work. Similarly, the researcher’s political commitment to specific goals demonstrates the overlap between engaged anthropology and potential applied aspects of an anthropology of policy.
With my involvement with the Georgia Latino Alliance for Human Rights (GLAHR), the Hispanic Health Coalition of Georgia (HHCGA), the Georgia Immigrant and Refugee Rights Coalition (GIRRRC), and the Cobb United for Change Coalition (CUCC), I made my political sentiments clear by exposing my interest in examining immigrant policing, its connection to health, and exploring it as a topic related to race. Exposing this set of political assumptions allowed me to develop and negotiate terms of reciprocity and engagement with each group I worked with. GLAHR leadership and members, for example, actively assisted me in finding immigrants to speak with and included me in every event and meeting they held, and even including me in “secret,” members-only spaces, such as a hidden Facebook page out of public view. Overtime I became a fulltime **GLAHRiador**, sharing the organization’s ideals of advancing immigrant rights and shared with the responsibilities of planning and participating in political actions. I provided GLAHR with skills I could offer, such as writing grants to advance their funding efforts, and GLAHR members assisted me in finding interviewees and suggested to me topics I should consider exploring, such as kidney failure among undocumented immigrants living in Atlanta and seeking treatment at Grady Memorial Hospital, as I discuss in chapter ten.

Similarly, my involvement with the HHCGA allowed me access to some health providers willing to be interviewed for this research and as part of my involvement I worked collaboratively with HHCGA members to provide and distribute a list of anti-immigrant laws in Georgia and their potential impacts on health providers. My involvement in GIRRC and CUCC connected me other immigrant rights activists who further aided in guiding my data collection as members aided me in identifying people that I should recruit for interviews and could triangulate stories that had surfaced through interviews and participant observation. All of these involvements connected me to a broader Atlanta-area activist network, where as many people
explained, including one CUCC member, “everyone knows everyone, and it’s the same group of people at all the meetings.” These connections opened personal invitations to attend events unrelated to my research efforts but were what others considered within the scope of my political ideals, such as attending Easter Sunday Services at Ebenezer Baptist Church to meet Shirley Barnhart, who fondly recalls her childhood crush on former church member Martin Luther King, Jr. A shared political objective between researcher and informants can thus allow anthropologists to have various types of engagement and act upon privilege and power differentials in ways that extend beyond questions of ethnographic representation. Moreover, shared political objectives facilitated a methodological dialogue between GLAHRiadores and GLAHR members and me. Inés for example, played a critical role in exploring dialysis as an immigration-related concern (discussed in chapter 10) and Julia and her comité members provided insight regarding some Grady Hospital providers’ stances of treating immigrant populations regardless of their legal status. Ongoing conversations with GLAHRiadores and other organization leaders further shaped my attention to family-related concerns, as I describe in chapter seven.

Although engaged anthropology shares similar concerns with postmodern approaches to anthropological research by acknowledging unequal power dynamics between research and informant and anthropology’s colonial history, the two perspectives differ in that engaged anthropology emphasizes anthropologists’ responsibility for social action. While “decolonizing” anthropology often includes reflecting on a researcher’s positionality and privileges through writing, activist anthropology takes the notion of decolonizing the discipline further and encourages anthropologists to take explicitly political, activist, positions allowing for an overt analysis of politics rather than downplaying them (Hale 2007; Speed 2008c).
Additionally, engaged anthropology extends beyond questions of representation and interpretation and situates anthropologists within a political system of action, calling upon anthropologists to make meaningful contributions with their often-marginalized research participants. Within engaged anthropology is a commitment to praxis—theoretically informed, politically motivated action to aid suffering populations. As Baba (2000) notes, “Praxis is not simply any kind of practical activity but a commitment to action that is organized explicitly around specific values and purposes, namely, those of liberating individuals from alienating and exploitative processes” (2000:26). A key component of praxis is a shift in which the researcher becomes not just an observer, but an actor with his/her participants in complicated social interactions occurring throughout the research process (Baba 2000: 26). Methodologically, engaged anthropology acknowledges the ethical and political tensions inherent in anthropological fieldwork, and brings critiques of political engagement to the forefront of research. As Speed (2006) argues, “[t]he benefit of explicitly activist research is precisely that it draws a focus on those tensions and maintains them as central to the work” (Speed 2006: 74). Through activist research, anthropologists can change the dynamic between researcher and informant, and address the unequal power dynamics of knowledge production (Speed 2008c). Activist research is thus an attempt to mitigate the exploitative research process in which the anthropologist extracts information from his or her research informants without interrogating his or her own privileges that allow for such a relationship or using privileges to benefit others. A commitment to changing contexts of inequality is not exclusive to engaged or activist anthropology, however, especially within the subfield of medical anthropology.
Engaged Anthropology and Health-related Research

Like engaged anthropology, some frameworks within medical anthropology, such as critical medical anthropology, have focused on challenging systems of inequality. Critical medical anthropology situates health within a political context embedded in power relationships and asserts a mission to not only understand causes of poor health, but also change “culturally inappropriate, oppressive, and exploitative patterns in the health arena and beyond” (Singer 1995: 81). Recognizing the body as the “terrain where social truths are forged and social contradictions played out, as well as the locus of personal resistance, activity, and struggle” (Scheper-Hughes 1994: 232), critical medical anthropologists have called attention to health-related consequences of inequality. Beyond identifying health inequities, however, critical medical anthropology examines the political economy of health to assess underlying causes of health inequity and asserts a mission to correct social inequalities perpetuating health disparities (Baer 1997; Singer 1995; Singer et al. 1992; Singer 1986; Singer 1989; Singer 1990; Singer 1994; Singer et al. 1990); a call to researcher action similar to engaged anthropology with an emphasis on health.

Critical medical anthropology thus represents a type of medical anthropology that fits within the engaged anthropology tradition of challenging politics creating inequality. In previous research I have drawn from this perspective to shape my data collection activities, theoretical perspective, and activist efforts (Kline 2010a; Kline 2010b; Kline 2013; Kline and Newcomb 2013). For the dissertation however, I have chosen to recognize critical medical anthropology as a form of engaged anthropology rather than use the perspective as a foundational concept because of critical medical anthropology’s roots in Marxist scholarship. This is not to suggest this research is incompatible with Marxist frameworks or fails to examine the political economy
of health. On the contrary, as described in the previous chapter, I note that Foucauldian notions of power account for political economy and are compatible with efforts to examine how power relationships may advance capitalist agendas. My choice not to focus on critical medical anthropology as a framework rooted in Marxist theories is instead an effort to maintain a theoretical consistency rather than applying numerous theoretical perspectives. Nevertheless, critical medical anthropology is a form of engaged research related to underlying causes of health inequality and deserves recognition for how the perspective encompasses calls to social action to correct systemic causes of poor health. Like critical medical anthropology, other forms of engaged research encompass calls to social action and further explore resistance movements.

Figure 3: Hugging a GLAH Riador during a Christmas Party where I received a thank you from GLAHR leaders for participating in events.

**Locating Resistance to Power Processes**

In addition to being a way of confronting disparate power dynamics created through policy, engaged anthropology can also provide a practical way of examining resistance to specific processes of power, including resistance to political power and applications of political
power that target marginalized populations, such as undocumented immigrants. As policy can be an application of power, resistance is a component of the power process that responds to specific applications of power. Finding oppositions to exercises of power can allow anthropologists to better explore power relationships. As Abu-Lughod (1990) writes, anthropologists can examine power by focusing on how some populations resist systems of power and domination, following Foucault’s statement: “where there is power, there is resistance” (1978). When researchers invert the assertion to understand that “where there is resistance, there is power,” they can better identify power structures at work.

Figure 4: Holding a banner as part of a protest against Stewart Detention Center in Lumpkin, GA.

Studying resistance and participating in resistance movements as an effort to locate power relations is useful in highlighting how power is applied, what the methods of application are, and how application of power from one group results in responses from another (Abu-Lughod 1990; Foucault 1982). Abu-Lughod contends that understanding resistance in this way
allows for examining resistance as a “diagnostic of power,” as Foucault puts it, which allows for tracing the “complex interworkings of historically changing structures of power” (1990: 53) and avoids romanticizing acts of resistance. In addition to being a diagnostic of power, as Abu-Lughod describes, resistance is a key component in exploring how power processes operate since power arrangements are relational and encompass resistance elements to specific power applications (Foucault 2002; Speed 2008c).

Assertions of power and resistance employ discourses in dialogical process; social movements can use discourses to challenge a specific application of power as part of a resistance effort. The discourse of human rights, for example, draws attention to numerous social and political struggles and has become the main and globalized discourse of resistance (Speed 2008). In Atlanta, resistance efforts often employed notions of “rights,” which were sometimes expressed as human rights and other times expressed through an understanding of entitlements going hand in hand with obligations, demonstrating ways immigrant rights groups made citizenship claims. By adopting an engaged research perspective, I developed a relationship with immigrant rights organizations like GLAHR whose resistance efforts allowed me to better understand immigrant policing as a set of practices that impact undocumented immigrants in numerous ways. By developing a relationship with an organization involved in a resistance effort, I was more able to examine a specific application of legislative power and its consequences.

---

18 Human rights discourses, however, are not neutral, value-free, apolitical, or exempt from critique. Even when adapted for specific contexts, human rights discourses emphasize culturally-laden values such as individualism and choice, which may or may not be appropriate depending on the context (Merry 2006). In this respect, resistance discourses such as human rights can serve the ideals of hegemonic power structures, but as Speed writes, human rights discourses may have the ability to “challenge sovereign power” and provide “alternative logics” (2008: 37) that can serve counter-hegemonic purposes.
Adopting an engaged research approach with GLAHR allowed to develop a close relationship with undocumented immigrants in the organization and directly responded to an overall research question of how immigration laws and immigrant policing, generally, govern undocumented immigrants. Immigrant rights groups such as GLAHR used public demonstrations to assert rights to entitlements such as driver’s licenses and demanding ends to arrests and deportations made possible through localized immigration enforcement regimes. These efforts demonstrated how localized enforcement regimes destabilize immigrants’ communities, and further showed how examining resistance efforts can help trace certain pathways of power, but with limits. Activism from GLAHR and other groups often focused on specific legislation or legislators and broader social concerns informing anti-immigrant rhetoric such as racism. Participating in actions of resistance allowed me to better understand how some immigrants interpret and respond to specific immigration policies as assertions of political power or race-based ideology. The type of activism I participated in as part of this research was not without challenges, however. Numerous scholars have described challenges and ethical concerns with engaged anthropology, as I describe in the next section.

**Ethical Considerations of Engaged Anthropology**

Although engaged anthropology attempts to address concerns related to unequal power dynamics between researchers and informants and can be a useful method for exploring resistance to specific applications of power, it can have serious ethical dilemmas. For example, researchers may romanticize the community with which they work, and as researchers become increasingly close to their activist communities, boundaries between researcher and activist may become unclear, potentially leading to conflicts that may not be easy to resolve (Pulido 2008). In addition, since activist researchers align themselves with a group facing a particular struggle,
researchers sometimes may face situations in which research agendas and political goals may conflict (Hale 2006). This is assuming, however, anthropologists work with populations occupying marginalized social positions; a different set of ethical considerations may be appropriate if anthropologists are working with populations who occupy positions of power, as I describe later in this chapter (Gusterson 1997; Marcus and Fischer 1999; 1969; Warren 2006: 220; Wedel et al. 2005; 2001).

During my time in Atlanta, researcher and activist boundaries sometimes fluctuated as I became a full member of organizations like GLAHR, allowing me an insider perspective into the organization, but occasionally was a sounding board to organization leadership needing to express frustration. Accordingly, I found myself thrown into the center of organizational struggles and conflicts. Staff members, for example, did not always agree with one another or get along, and I was sometimes put in the middle of disagreements between GLAHR staff members. These disagreements were not always made known to the rest of the GLAHRiadores, but these experiences indicated how as a researcher I occupied dual role of participant and outsider privy to information other insiders were not. I have chosen not to report specifics of these situations in the dissertation, however, out of fear that potential misuse of the information could undermine GLAHR and by extension the immigrant rights movement in Atlanta.

Despite ethical and practical dilemmas such as navigating organizational politics, engaged research allows for developing meaningful relationships in order to make a positive change in the lives of people affected by systems of inequality. This effort is part of a commitment to fieldwork that actively rejects exploitive research dynamics and can lead to a deeper understanding of the lives of populations with which the researcher works. Activist methodologies can thus allow for collecting “better results” (Hale 2001; Speed 2008c; Stuesse
2008), as participants may become more invested in research by participating in data collection activities, designing research questions, and validating findings (Hale 2001). Involving research participants in data collection may not be feasible, however, since data collection requires resources such as time, money, and mobility, which were not all available to undocumented Latino immigrants living in Atlanta. For undocumented Latino immigrants in Atlanta, involvement in data collection activities may require traveling throughout the metropolitan area, which may have heightened their exposure to police. Moreover, involving participants in data collection without a form of compensation potentially exacerbates exploitative processes since participants may be serving as de facto research assistants but will not reap the career benefits resulting in a publication that the academic researcher will. This research therefore did not involve participants in data collection activities.

Although participants were not involved in collecting data, GLAHRIadores and other participants played a role in guiding research questions and determining topics that deserved additional attention. Through my engagement with GLAHR and other groups, for example, I focused on end-stage renal disease and family relationships, which were not initially part of the research plan. This type of collaborative prioritizing of research ideas not only involves participants in the research design process and challenges traditional research inequalities’ that assert binaries between researcher and informant, but also fits well with the goals of multi-sited ethnography in following research themes as they emerge.

**Studying Networks and Connections: The Case for Multi-Sited Ethnography**

Research on the consequences of immigration policy demands a multi-sited approach, particularly when exploring how policy impacts individuals’ health, family relationships, shapes community-based activism, and plays a role in the broader healthcare system. Examining the
numerous levels of impact of immigration policy therefore requires adopting a methodological approach such as multi-sited ethnography, which accounts for the need to follow concepts through different social spaces.

Multi-sited ethnography developed as a way to explore globally connected phenomena that are not immediately visible in one setting. Anthropologists examining globalization at its consequences have raised methodological questions about how to study global networks instead of localized communities and where to conduct fieldwork on globalization itself (Abram 2003). These questions are not limited to research on globalization and can be applied to other social phenomena, such as the multitudinous impacts of policy. Whereas place was once the locus for anthropological inquiry, anthropologists are now challenged to examine networks, objects, social relationships, or notions that are meaningful or characterize social groups that span across numerous spaces (Abram 2003; Amit-Talai 2000; Hannerz 1996; Miller and Slater 2003).

A great deal of ethnographic work focuses on a single site of observation and entails participation rooted in contextual research about a broader system. Multi-sited ethnography, on the other hand, is a methodological shift away from deeply studying one space to moving across multiple spaces, tracing, following, or tracking a specific idea or object throughout a system of interactions (Marcus 1995). Anthropologists use multi-sited ethnography to examine “paths of connection” through different spaces (Marcus 1995: 98), allowing for a dialogue between the many sites to be revealed, including dialogues of power and resistance. Shannon Speed, for example, highlights the ability to trace relationships of power in her work in Chiapas (2008); as conflict spread from one region to another, Speed traveled across communities and eventually documented a dialogue of resistance between communities, finding the “path of connection” through human rights discourses. Whereas Speed’s activist research was multi-sited by necessity
due to violence pushing her from one site to another, this research was multi-sited from the onset, and was designed to study the paths of connection created through immigration policies.

Applying a multi-sited ethnographic approach to research examining policy is necessary since an anthropology of policy necessitates exploring the impacts of policy in multiple spaces, contextualizing “the field” as a set of “loosely connected actors with varying degrees of institutional leverage located in multiple “sites” that are not always even geographically fixed” (Wedel et al. 2005). Examining numerous social actors in multiple spaces who may not always be in contact with one another makes it possible to “study through” (Shore and Wright 1997) relationships of power and resources across time and space (Wedel et al. 2005). Additionally, following policies through different contexts can reveal “varying interpretations of events from the viewpoints of different social actors” (Abram 2003: 156), which can highlight tensions related to applications of power and how resistance is conceptualized. Multi-sited ethnography can also shed light on how a particular system of interactions operates, as demonstrated by Nancy Scheper-Hughes’s (2010) multi-sited work on human organ markets, highlighting ways in which some medical economies follow early forms of mercantile global capitalism (Scheper-Hughes 2010: 36-37).

Following social phenomena through different social spaces and among different social actors is therefore the greatest strength of multi-sited ethnography. Unlike ethnographies that consider multi-level impacts, multi-sited research involves specifically following an idea and engaging in research activities through different social spaces. In this research, multi-sitedness took shape in conducting interviews with immigrants in their homes, physicians and administrators in health care facilities, immigrant rights organization leaders in their offices, state legislators, and involved participant observation activities at health facilities, the Georgia State
Capitol, and across numerous locations with immigrant rights groups and health organizations.

While these experiences enriched my understanding of the health and health policy related impacts of immigration laws, they presented challenges, such as carefully articulating my research to policy makers, considering how to write findings from policy makers while keeping and engaged perspective, and being “thinly spread” in the field, as Scheper Hughes (2004) describes.

As this research was multi-sited from its inception, policy makers were a key group for interviews, providing a potentially challenging positionality balance as an activist researcher committed to immigrants’ rights but attempting to glean information from a group that does typically voice support for undocumented immigrants. In conceptualizing this research, I embraced Laura Nader’s call to “study up,” or specifically study “the culture of power and not the culture of powerlessness” (1969: 289) as part of how anthropologists can conduct domestic fieldwork that challenges an “us/them” research binary based on exoticization (Ortner 2003: 2), but remained committed to my political alignment with organizations such as GLAHR. These two approaches could have been conflicting, and I reconciled possible tensions by considering the ethics of “studying up.” Borrowing Wedel’s (2001) perspective that studying “up and through” requires reinterpreting the American Anthropological Association (AAA) Statement on Ethics\(^\text{19}\) to treat powerful institutions and actors as sources, much like journalists do, I viewed information policy makers provided as information others have a right to know (Wedel et al. 2005). This perspective does not remove a responsibility to protect informants, however, and as Gusterson (1997) asserts, anthropologists must not exoticize or objectify informants, even though some anthropologists may contend that using ethnographic authority in writing about the

---

\(^{19}\) The AAA statement asserts that anthropologists’ informants are their primary responsibility.
powerful balances their already powerful positions (Price 1995; Gusterson 1997). Embracing an activist methodology but conducting multi-sited research that includes policy makers thus provided possible complications in writing the findings presented in this dissertation. To address the potential of unfairly representing policy makers, I kept in mind Warren’s assertion that social scientists must produce credible work that avoids “reproducing older polarizing discourses, without idealizing social movements or demonizing and essentializing at least one party in our social analysis” (Warren 2006: 220). As such, I have avoided suggesting social movements or immigrant rights organizations in Atlanta were ideal organizations without problems or representing policy makers as a monolithic group inherently against undocumented immigrants.

Furthermore, in this research, representing powerful groups such as policy makers was not as large of an ethical quandary as it could have been because many of the legislators I spoke with were sympathetic to immigrant rights’ causes if not immigrant rights activists themselves. Some of the legislators I spoke with, for example, outwardly supported immigrant rights organizations so strongly that they became targeted for anti-immigrant violence and vandalism. Similarly (and beyond the scope of legislators), clinic owners who identified as financially conservative expressed their outrage regarding Georgia’s immigration laws and associated impacts on immigrants, and physicians I spoke with shared similar sentiments. My experience stakeholders who occupy positions of power and therefore fit into the framework of “studying up” is in part because powerful decision makers who were hostile towards undocumented immigrants’ rights refused interview requests, including legislators who supported HB 87. Interview refusals point to how some powerful groups may use their authority to hide from researchers,
underscoring a need for multi-sited research that includes “studying up” so that powerful groups like legislators are not omitted from research inquiry based on their positions alone\(^2\).

Populations holding powerful social positions and avoiding researchers is perhaps a product of the “cultural invisibility of the powerful,” since chosen invisibility is a part of the privilege of the powerful (Gusterson 1997). Powerful agents are able to shroud their power with technologies of security, exclusion, and secrecy, and while some anthropologists may attempt to study the powerful covertly, as Gusterson (1997) highlights, other scholars have indicated the importance of making it clear that powerful decision makers are participating in research (Ho 2009; Traweek 2009). Accordingly, I disclosed the research nature of my reason for contacting all participants, which may have influenced some legislators’ choices to decline participating, but recognized the risk of non-response was part of potentially getting a better understanding of immigrant policing, as Heyman asserts is possible with “power-wielding bureaucrats” (Heyman 2004). In chapter five, I describe ways in which some lawmakers avoided contact with me in greater detail, suggesting how legislators’ use of secretaries to relay rejection messages and declines for interviews may have been a technology of invisibility to avoid research attention. Nevertheless, the potential for powerful position holders to avoid research scrutiny bolsters a need for multi-sited research involving powerful groups as part of a research design since they can provide important insights regarding social phenomena.

In addition to the challenges in balancing an engaged research perspective with a multi-sited approach that included interviewing policy makers, multi-sited ethnography is further complicated by having multiple field sites. Multiple sites means multiple spaces demanding the

\(^2\) This echoes Nader’s assertion that anthropologists typically do not study up and only study the marginalized, a claim Sherry Ortner makes while also providing examples of early ethnographies of domestic fieldwork (Ortner 2005:2).
time of the anthropologist, which can lead to the anthropologist being too “thinly spread,” as Nancy Scheper-Hughes (2004) has warned. Being too thinly spread may result in a lack of a deep understanding of one specific field site, but it allows for a more complex and understanding of how intangible forces impact specific contexts or how objects are received and interpreted in diverse locations. Similarly, a challenge in having multiple field sites is conceptualizing research actions. Tracing pathways of connection may begin to seem ambiguous, especially if multi-sited research methods are combined with activist methodologies that draw researchers into close relationships and strong bonds with certain groups. Conceptualizing how to do multi-sited research can therefore be challenging, and to address this challenge, I borrowed from a health sciences model to consider how to trace social phenomena that are interconnected, separate, and impact health. This model ultimately guided data collection activities and provided a way to visualize how connections are possible for groups of people that may lack interaction.

![Bronfenbrenner's Ecological Systems Model](http://geopolicraticus.wordpress.com/2011/03/23/ecological-temporality/)

---

Figure 5: Bronfenbrenner’s Ecological Systems Model

---

To attempt to visualize how pathways of power, and immigration enforcement regimes, specifically, may impact numerous different social spaces, I drew from social science theories examining the “ecology” of social phenomena. Conceptualizing multi-sited ethnography through an ecological lens allowed for me to methodologically find how to conduct multi-sited research. Borrowing from my academic public health training, I used Urie Bronfenbrenner’s (1979; 1997) Social Ecological Systems model\(^{22}\) (see figure 1) and the social ecological model of health\(^{23}\) (see figure 2), used in health sciences, to consider how immigrant policing had health-related impacts on several different social levels, ultimately affecting individual immigrants, their families, their social organizations, and health care settings. By combining a social ecological perspective with multi-sited ethnography, this research blended the analytic utility of a health sciences model with the ethnographic richness of multi-sited ethnography to highlight the lived experiences of those

\(^{22}\) Urie Bronfenbrenner explains human growth and development as being part of an ecological system comprised of five subsystems—micro, meso, exo, macro, and chronosystems. Microsystems are the immediate face-to-face relationships with others that an individual has through family relationships, workplaces, social organizations, and neighborhoods. The mesosystem describes linkages occurring between the person and least two other settings within the microsystem. In the exosystem, linkages between settings occur but do not directly involve but do directly impact the person at the center of the ecological model. Examples could include political systems, school settings, and the local built environment. The Macrosystem contains overarching social beliefs and values, while the chronosystem describes how time changes all of the subsystems. Bronfenbrenner’s model (see figure 5) influenced other ecological systems models, including the social ecological model of health, a prevalent model in the field of public health used to explore health determinants and design health interventions. In this research, I use Bronfenbrenner’s ecological systems model to map research activities and map the methods of data collection used for this research.

\(^{23}\) The social ecological model of health describes how health is situated within a social context determined by numerous social factors that influence one another. As a prominent model used in public health, the social ecological model informs numerous health programs and interventions. This version of the Social Ecological Model is from the Agency for Healthcare Research and Quality (AHRQ) and was obtained from an AHRQ website: http://www.ahrq.gov/professionals/prevention-chronic-care/resources/clinical-community-relationships-measures-atlas/ccrm-atlas3.html
affected by immigrant policing and detail how immigrant policing pervades multiple social levels.

Figure 6: The Social Ecological Model of Health

Sources of Data Collection

To understand the impacts of immigration policies, I conducted semi-structured interviews (see table 1) with undocumented immigrants (n=12), health care providers (n=18), health-related NGO leaders and staff (n=9), non-clinical hospital staff and administrators (n=4), state agency workers (n=3), elected officials (n=3), and leaders of immigrant rights organizations (n=2). The 51 formal interviews were also supplemented by 14 informal interviews with immigrant rights organization leaders (n=6), health NGO workers (n=3), health department officials (n=2), undocumented immigrants (n=2), and health care providers (n=1). Furthermore, as a graduate research assistant for a National Science Foundation (NSF) funded project titled: “The Devolution of Immigration Enforcement in the U.S. South and Its Impact on Newly Established Latino Communities” (PIs Angela Stuesse, PhD and Mathew Coleman, PhD), I conducted 49 semi-structured interviews with undocumented immigrants, immigrant rights leaders, and others impacted by immigrant policing, and co-conducted or observed another 23
semi-structured interviews with PI Stuesse. In this dissertation, I primarily use interview data from the interviews not collected for the NSF grant and have drawn from NSF interviews to describe some informants’ backgrounds but did not systematically analyze or use the majority of these interviews for reporting information here.

<table>
<thead>
<tr>
<th><strong>Formal Interviews</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td>Providers</td>
</tr>
<tr>
<td>Immigrants</td>
</tr>
<tr>
<td>Health-related NGO staff</td>
</tr>
<tr>
<td>Non-clinical Hospital Staff (e.g. Administration, Social Worker)</td>
</tr>
<tr>
<td>State Agency Worker</td>
</tr>
<tr>
<td>State legislators</td>
</tr>
<tr>
<td>Non-health NGOs</td>
</tr>
<tr>
<td>Taxi Drivers</td>
</tr>
<tr>
<td>Immigrant Rights allies</td>
</tr>
<tr>
<td>Business Owners/Business Organizations</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
</tr>
</tbody>
</table>

Table 1: Interviews conducted and for which project the interviews were conducted.

In addition to interviews, I also engaged in 125 separate participant observation experiences in the state capital, with immigrant rights organizations, in health facilities, with

---

24 Some participants were interviewed more than once; the total number of participants interviewed for the NSF was 68 despite conducting 72 interviews.
25 All but five mentioned being undocumented and documentation status was not a direct question.
health organizations, or at another type of political demonstration, most often organized by GLAHR. While interviews and participant observation experiences served a data collection techniques, they also served as avenues for making applied contributions while conducting research. At events that GLAHR organized, for example, I was able to assist with carrying banners or play a role in a popular education event. This form of participation not only provided an additional body to engage in GLAHR’s efforts, but also demonstrated a broader sense of solidarity for immigrants’ rights. As such, interviews and participant observation experiences were grounded in multi-sited and engaged research methodologies, as I conducted interviews through multiple social spaces to trace the impacts of immigrant policing and become a full member of GLAHR by participating in GLAHR events and weekly meetings.

**Interview Recruitment and Eligibility**

Conducting interviews with a variety of groups required a recruitment method appropriate for vulnerable populations and groups with significant time constraints (such as legislators and health providers). Accordingly, participant-driven recruitment (PDR) served as the primary recruitment strategy for interviews, which relies on a referral process to find new participants and is often used among hidden populations (Heckathorn 2002; Tiffany 2006). While PDR played a large role in recruiting participants, some participants were also be recruited through publically available means, such as through a media analysis and online database of health service facilities. These participants included elected officials and health service providers at Grady Hospital. Physicians, specifically, were recruited from contact information on the Grady Hospital website. To be eligible to participate, all interviewees must have been at least 18 years of age. Health providers must have been a health provider in Atlanta for at least one year, agency workers must have worked in their state agency for a minimum of one year and had
direct contact with undocumented immigrants, and hospital administrators must have had at least one year of experience in their administrative position. For health-related NGOs, staff members must have been at an NGO that was in operation for at least two years and provided charitable or low cost services to needy populations and serve immigrant patients. Non-health-related NGO staff were eligible to participate if they spoke English or Spanish and had worked at their organization for at least six months. Non-health NGOs were identified by having an explicit immigrant rights focus and working on immigrant rights related topics rather than providing health services. Undocumented immigrants’ eligibility included speaking English or Spanish and having lived in Atlanta for no less than four years.

Archival Media Analysis

To triangulate interview and participant observation findings, I conducted a media analysis of major news stories related to immigration policies, which further shed light on immigration discourses in Georgia. After developing a set of keywords related to immigration, I searched major Georgia media outlets such as newspapers, television networks, and magazines for keywords using databases such as ProQuest and WorldCatNews. A total of thirteen media sources available in the Atlanta area were searched; the top three English language newspapers based on readership, the top two Spanish language newspapers based on readership, the top three English language television stations and top two Spanish language television stations based on viewers, and top three English language periodicals based on readership. Keywords that operated as search terms included immigration, immigrant, HB 87, Secure Communities, 287(g), and the word “immigrant” with terms such as drivers licenses, health care, jobs, and agriculture. The search range included all days from 2002 to 2013, and search results were coded and analyzed using NVivo. These data were collected as part of my role as a research assistant on the NSF
grant, and although specific media analysis findings are not dedicated space in this dissertation, I cite to several media stories to support interview claims and ideas that surfaced through participant observation experiences. The archival media analysis served to triangulate interview and participant observation experiences and also provided an understanding of immigration rhetoric that helped inform research questions and data collection activities.

**Interview and Field Note Data Analysis**

All interviews were recorded, transcribed, and analyzed for themes using the qualitative data analysis software MAXQDA. The software allowed for storing fieldnotes and interview transcriptions by theme or topic, which facilitated coding and data organization. Codes were created directly from research questions and based on theoretical constructs; as major themes developed, new codes were created. A priori codes were developed based on theories of biopolitics, citizenship, critical race theory, and notions of deservingness. Inductive codes were developed after reading all of the interview transcripts and making analytical memos from field notes. Interviews were coded based on a descriptive coding method in which portions of text were assigned short words or phrases summarizing the basic topic (Saldaña 2009: 70). These codes were then cataloged and frequenced in MaxQDA, and I looked at the codes with highest frequencies to start developing themes. I then compared codes with largest frequencies to codes with smallest frequencies for relationship.

**Challenges**

This research is limited by a number of factors. First, no demographic data were recorded for undocumented immigrants, which presents a potential drawback for future data analysis that would seek to contextualize data with, e.g., migration trajectory from country of origin to Atlanta, average number of years spent in the United States, average family size, and income. These data
would provide descriptive statistics on some of the immigrants living in Atlanta, which may be helpful in arguing how embedded immigrants are in their local communities given their length of residency and economic contributions. These variables were not of specific importance to the current research, however, and were omitted in order to increase anonymity and avoid any suspicions of what the data could be used for. During my time in Atlanta, I frequently heard stories of undocumented immigrants fearing anyone and any institution associated with “the government.” Large institutions like hospitals were often considered the face of “the government,” where recording vital information and associations of recordkeeping alarmed many of the people I came into contact with. Given my position as a native English-speaking white male, I was aware that my positioning could arouse suspicions and fears. Moreover, given the strong feelings of fear among many participants, I felt it inappropriate to collect data that would allow any participants to fear the use or purpose of the data. As such, I purposefully avoided recording information that could be perceived as being used for future identification of interviewees. Following the American Anthropological Association’s Statement on Ethics and the primary ethical obligation of anthropologists to do no harm, I assert that engaging in forms of data collection that would have lead to the unnecessary and unjust fear among research participants for my own personal, scholarly gain does harm and demonstrates a disproportionate allocation of the benefits and burdens of research.

Additionally, this research is limited by what is a simultaneous strength—its multi-sited nature. My participant observation and interviews with populations connected by one idea or policy but otherwise possibly very separated required me to constantly be changing roles, reframe my research, and even adjust my appearance. In the state Capitol, for example, suits and ties were expected of anyone meeting with a legislator, along with a general demeanor of
formality. When meeting undocumented immigrants at their homes, however, I had to ensure my style of dress did not suggest any association to a government agency or anything that would merit distrust, and more casual attire was necessary. On one occasion when I went to an undocumented woman’s home after being in the Georgia Capitol and had not changed my clothing, the informant saw me for the first time through the peephole in her front door, dressed in a button-down shirt and holding a briefcase. Fearing I may be a government official, the woman did not answer the door when I knocked, or answer her phone when I called. I later got to know this woman through my involvement with GLAHR and then learned she did not initially answer the door when I first visited her home because she feared I was someone from the government. As this scenario demonstrates, the constantly changing nature of multi-sited ethnography requires research adjustment in ways that are both obvious and subtle. Clothing and appearance were often part of the adjustments I needed to make, and other, subtler behavioral changes like controlling facial expressions with some interviewees were required in order to not alienate politically conservative research participants. These challenges demonstrate the difficulty in multi-sited research that may not always be easily resolved. Changing clothing may be easy enough, but controlling facial expressions during an interview and controlling my immediate reactions is not as simple as replacing a button down shirt with a t-shirt.

The challenges associated with interviewing various groups for this research further speak to my positionality as a privileged white, male, researcher earning a doctorate degree and holding liberal political views. My race and class in particular\(^\text{26}\) undoubtedly challenged my ability to build rapport with some people depending on the context. In one conversation early on

\(^{26}\) My politics also made for challenging data collection as no Republican lawmakers were willing to speak with me for a variety of reason, as I discuss in chapter four. This challenge would not have been as significant for a researcher with connections to Republican political organizations and leaders.
during my fieldwork, for example, a GLAHRíador asked me somewhat accusingly about my interests in undocumented immigrants. “And you, why do you care about this?” she asked, gesturing towards me with a look of suspicion that I can only assume was linked to my race and social class. Reflecting on my research interests and how I saw them personally connected to my own experiences, I explained to her that I cared deeply about undocumented immigrants’ rights because of my positioning as a gay, Jewish male, and the type of discrimination that I have experienced as a result of my identity. I further added my perspective that all forms of discrimination were linked to efforts to divide and control populations, and that I felt it was my job as an activist researcher to shed light on forms of discrimination and injustice in an effort to unite marginalized groups and inspire social change and political action. Moments like these allowed me to commiserate with some of the immigrants I met in Atlanta, and helped me earn their trust.

Further complicating my position was my language ability since I participated in GLAHR events and conducted interviews in Spanish. Although I am proficient in Spanish, I am not a native speaker, and my occasional linguistic difficulties led to humorous moments when I could not remember a word and attempted circumlocution. In every circumstance possible, I used my language ability as a way to balance power dynamics related to educational opportunities. Whenever I was unaware of a word or phrase during an interview I asked the interviewee to explain it as an act of not only ensuring understanding, but also as an effort to position myself as a student learning from the interviewee rather than a researcher. In many scenarios, however, my language skills made me feel somewhat juvenile, which ultimately aided in viewing me as less threatening.
Moreover, my connections to some organizations limited my ability to work with others. My close alignment with GLAHR, for example, led one organization leader to question whether to participate in an interview with me. This organization leader had a rift with GLAHR leadership, and as a result of my position as a GLAHR collaborator, he was cautious about what to share regarding immigrant advocacy. Similarly, my involvement in GLAHR limited how other groups’ leadership viewed me, expressing anxieties over being seen working with GLAHR since they were viewed as “radical.” My close relationship with GLAHR also afforded me access to other activists and immigrant rights groups, and ultimately I was able to develop a strong relationship with GLAHRiadores. This tension reflects the broader challenges associated with multi-sited ethnography and directly reflects the choices I made in conducting multi-sited research as an activist anthropologist. Weighing my activist commitments stronger than other
commitments, I chose to devote more time with organizations like GLAHR and prioritized participant observation experiences with undocumented immigrants. Choosing among “competing” field sites in multi-sited ethnography therefore requires frequent methodological reflexivity, and in my case, I was cognizant of my choice to conduct engaged research and align my politics with GLAHR, thereby privileging opportunities to spend time with GLAHR if competing opportunities arose.

**Applied Contributions**

Inspired by Bastide’s (1973) claim that applied anthropology is a science of politics and praxis, and Ervin and Mackay’s (2000) assertion that “policies provide blueprints for actions,” this research aimed to develop collaborative relationships with undocumented immigrants to positively impact their lives and aid in policy development that helps reduce social inequities. In addition, this research had a goal of informing policy, but this effort has not yet developed. Like many anthropologists doing applied research, I ultimately shifted my intended contributions to meet the desires and intentions of the organizations and people I collaborated with. For some organizations, my skills and time were needed in specific ways; GLAHR, for example, needed me to write grants to secure their future funding, help promote and participate in popular education events, assist with writing press releases and contacting media, or do any daily activity a GLAHR staff member or volunteer would be asked to do. I happily obliged with these and other requests, and at least one grant writing effort resulted in funds for GLAHR. Nevertheless, assisting with organizing marches, rallies, and popular education events helped GLAHR achieve specific goals while I worked with the organization, and removed the burden of small tasks from some of GLAHR’s leaders, such as proofreading and sending press releases to media outlets. This type of deepened involvement allowed me to become a full member of GLAHR, sharing the
responsibilities of the organization and also allowed me to contact and recruit more interview participants.

Similarly, I worked with Hispanic Health Coalition of Georgia (HHCGA) staff to create a list of immigration laws that impact Latino patients and provided recommendations to health providers regarding this topic. From this endeavor came a larger, collaborative project from HHCGA volunteers, and medical, nursing, law, and physical therapy students at Emory University. This collaborative project manifested in a seminar at Emory University focusing on undocumented immigrants’ access to health services and featured anthropologist Seth Holmes (among others) as a speaker. Although this event took place after I left Atlanta, I assisted with planning it while in Atlanta and back in Tampa, and helped develop the discussion themes. In this respect, I successfully adopted strategies used for making policy impacts, following Charnley and Durham (2010). These strategies including playing the role of intermediary (Rylko-Bauer et al. 2006; Sanjek 2004), linking organizations together, and contributing to public conversations about research findings that engage with broader audiences, including media and political leaders (Sanjek 2004), and engaging in research that includes community members and leaders, who can then influence policy (Austin 2004; Haenn and Casagrande 2007; Lamphere 2004). Moreover, with informal reports I provided the HHCGA and reports I have offered to write that are still pending, I was able to adopt a traditional model of “policy science” where research conducted is given to a group of stakeholders who can then use the research to inform policy (Heyman et al. 2009b). These efforts have not yet developed into any measureable outcome or impact, however, and in some cases, such as the Hispanic Health Collation, have not materialized in further action since the organization changed its leadership immediately after I
left Atlanta. This situation in particular suggests to how products given to stakeholders are beyond researchers’ control for further dissemination efforts.

Figure 8: At one of the immigrant rights marches I assisted GLAHR with organizing.

Despite the short-term benefits of my involvement, this research was also applied as it was guided by a political stance opposing policies that prevent undocumented immigrants from accessing health services and restrict their ability to engage in daily activities. My position as a white male researcher working with an activist Latino organization seemed to have meaningful implications to some of the participants involved in data collection. One participant, considering my positioning as a non-Latino white male, and reflecting on how immigration policies were informed by racial ideologies, expressed how thankful she was knowing that someone cared about the hardship she experienced in Georgia. Several participants expressed feeling grateful that someone listened to their stories of hardship, and appreciated that someone else knew about what they saw to be examples of racism and inequality. These expressions of gratitude were
troubling, however, as they suggest that my knowledge of immigrants’ hardships was more powerful than their knowledge and experiences, reproducing racial power imbalances and a discomforting deference I was unsure of how to respond. In reconciling this discomfort, I aim to share stories of undocumented immigrants in Atlanta in an effort to draw attention to the consequences of immigrant policing that necessitate intervention. In the following chapters, I describe in greater depth my participation with immigrant rights groups, the struggles many undocumented immigrants in Georgia faced, and the way in which immigration policies impacted undocumented immigrants, health providers, and the overall health system in the United States.
CHAPTER FIVE
UNDERSTANDING POLICY MAKERS’ PERSPECTIVES IN GEORGIA’S IMMIGRATION LAWS

Introduction

During my first weekend in Atlanta, I traveled with Inés to southern Georgia visiting three small towns: Tifton, Fitzgerald, and Warner Robbins. As we drove down the highway in a rental car listening to Inés’s newly-purchased social-justice themed Starbucks album, I asked Inés why various immigration laws passed in Georgia, including the Arizona copycat law, HB 87.

“These Republicans passing all these laws—ay ay ay! They are destroying our communities, they are breaking up families, and it’s sad.”

“Why do you think they passed these kinds of laws?” I asked.

Inés, without taking a breath, immediately answered: “because they are racist! They don't like immigrants.”

As Inés and I talked about the bill’s co-sponsors and how HB 87 was described in public media, she expressed frustration over who supported the bill the legislature.

“You know we had a Latino vote for it? David Casas. Sí, ‘manito. He voted for it and he is Latino. We call him ‘David Homes.’” Inés explained, hinting at the racial politics behind HB 87 and other immigration laws. She then explained that HB 87 allowed for local law enforcement to engage in what she saw as racial profiling, and that routinely stopping Latino drivers who did
not produce valid licenses put them at risk of being deported and their families at risk of losing them to the deportation process.

“You’ll see how in some of these stories we hear when we stop. It’s very sad.”

In each town we stopped, Inés met with local community members in churches to share information about 287(g), Secure Communities, and HB 87. During these meetings, community members shared stories about being stopped by police, getting arrested, and needing advice. In one town a woman with small children worried about being arrested several weeks earlier, noting the stop was for a vehicle problem.

“They stopped me because they said my tail light was out, but I always check it,” she explained. “I always check my lights and I know it was fine. I was in jail for three days and I have this fine... I have to go to court,” she said to Inés, anxiously. “What do I do?”

Inés began taking pictures of the documents with her phone (see Figure 9). “Give me your phone number and I’ll take this back to the office and see what I can find out.” Redirecting her attention to the room of 3 others, she made a plea for community activism. “This is why we have to organize—these types of injustices! We can help you organize and confront local police and demand that they stop pulling people over just because they are Latino.” In an effort to organize the room of four, Inés suggested marches and issuing demands to the police. Her passionate and compelling plea inspired nods in the room, but some expressed discomfort with the idea of exposing themselves to local police, asking why Inés could not just deal with the police herself.

“Because I don’t live here.” Inés answered. “I live in Atlanta. You all are the ones that live here and face this every day.”
This type of interaction happened among the gatherings of 4-20 people in every town we visited. Two towns had few attendees, which Inés suspected was the result of poor communication between points of contact and community members. “It’s the pastor’s job [at the church where we met community members] to remind people the meeting is happening so they come—he says he did it, but I don't think he did. Four people showing up to a meeting? Come on!” After our final stop in the two-day trip and during our drive back to Atlanta, Inés reflected on stories she heard during our visits to the three towns.

Figure 9: Assisting a woman with legal documents.

“These stories are so typical—‘I got stopped for no seatbelt,’ or ‘I got stopped for a broken taillight,’ or they just stop people for no reason at all. It’s destroying our community,” Inés said staring at the road, occasionally interjecting with comments about drivers’ recklessness. “We have to fight these anti-immigrant laws! Pinche cabron—you see that? No turn signal.”
Stories from immigrants I met in the visit to southern Georgia were indeed similar to other narratives of immigrant policing I heard while living in Atlanta, demonstrating how localized immigration enforcement through 287(g), Secure Communities, and HB 87 operated: Latino drivers would get stopped for traffic concerns of minor vehicle problems, would be asked for a drivers’ license, and upon not producing one or not producing a valid, Georgia licenses, could be arrested and eventually have their immigration status discovered. These impacts deserve attention to understanding policy makers’ articulated resigning for technologies of immigrant policing that result in immigrant resistance efforts and mobilization responses such as Inés encouraging immigrants to demand police stop pulling them over.

This chapter draws from interviews with legislators, conversations with lobbyists, and participant-observation experiences in the state Capitol and at Immigration Enforcement and Review Board (IERB) meetings to assess legislators’ aims in passing HB 87 and other immigration laws that advance localized immigration enforcement agendas. As I demonstrate in this chapter, legislators’ support of laws like HB 87 can be understood through Foucault’s notion of race-war logics (Foucault 2003) that speak to racial anxieties about demographic changes in Georgia and Atlanta and efforts to support neoliberal aims in shrinking state services by asserting non-eligibility of entire populations for entitlements. Because undocumented immigrants provided a politically convenient topic for legislation, legislators’ support for immigration laws like HB 87 can further be understood as what Rose and Novas (2005) call “citizenship projects,” which entangle the way policy makers act upon certain groups of people. Ultimately findings in this chapter suggest how immigration policies in Georgia are an efficient technology of power that serve biopolitical and anatomo-political objectives (Foucault 2003).
Experiences at the Capitol and Interviews with State Legislators

During the 2013 Georgia legislative session, I frequented the state capitol to meet with legislators, lobbyists, activists, and attempted to get information on specific immigration-related bills. Entering the Georgia Capitol requires passing through a security station situated at the entrance. The interior of the capitol combines federal-style architecture with what I envision as a local sheriff’s office from the early 1900s. White marble floors, Roman columns and stone balustrades bounce noise across the open spaces and against deep-brown wooden doors with transoms letting in light from the large windows near the ceiling and main-street-style lampposts with globe casings casting dull glows from incandescent bulbs. The capitol was frequently hectic when the General Assembly met, but guards often recognized repeated visitors, including me on a day I went to look for Matt Ramsey, cosponsor of HB 87.

“How are you doing today?” A thin, white, middle-aged security guard asked me, recognizing that I had visited a few days prior.

“I’m cold! I haven't gotten used to this kind of weather.”

“It’s not like this in Florida, now is it?”

“No, it’s certainly not!” I responded, passing through the metal detector that sounded a disapproving buzz. “It must be this,” I said, starting to remove my watch. “I usually take it off, but when I was at a meeting across the street in the legislative office building and I forgot—the machine didn’t make a sound.”

“They’re all different—don’t worry about it, you can go on through.”

“Oh thanks,” I said, re-clasping my watchstrap.

“You have a good day now,” the guard said to me with a nod and a smile.
“Thank you, you too,” I replied, twitching an immediate frown into a smile to hide my annoyance with the production of security that had no real meaning and recognition that I had received a privilege many others would not—the assumption of being non-threatening simply because of my appearance as a well-dressed white man and my demeanor.

After climbing the stone stairs to Representative Ramsey’s office, I was greeted by his assistant with a smile and a “Hi there, how can I help you?” in a Georgia accent.

“Hi, my name is Nolan Kline and I’m trying to set up a meeting with Mr. Ramsey. Is there a way I could find a time to meet with him?”

“Mr. Ramsey handles his own schedule so you’ll have to talk directly to him,” she responded as I glanced to my right into Ramsey’s office, noticing the empty chair behind a large wooden desk. “But I can take a message for you and let him know as soon as he’s in.”
“Do you know when he’ll be back? I can just wait here.”

“He’s actually not going to be back until the end of the day and then he’s heading straight out for his son’s baseball game, but I’ll be sure he gets your message. What did you say your name was again?”

“Nolan Kline.”

“And what was it you wanted to speak to him about?”

Deciding to be straightforward since Representative Ramsey and his assistant had not responded to my emails and voicemails requesting to speak about immigration, I went ahead and revealed my specific intention to discuss HB 87. “I wanted to talk to him about HB 87—”

“Oh, you’re the one from Florida.”

“I am!” Clearly his secretary had gotten my messages but did not feel they were important enough to deserve a response. I quickly attempted to persuade her why Ramsey should speak to me. “I’m trying to reach out to everyone I can about HB 87 and I’d really like to talk to Mr. Ramsey because so far I’ve only spoken to Democrats, and I’d like to be fair and balanced [I intentionally used the Fox News language]. They’ve been the only ones telling me about it and I’d like to be fair and hear from both sides, especially from Mr. Ramsey since he’s the most knowledgeable.”

“Mmmhmmm,”

“It’s just not fair if the Democrats are the only voice I hear from, so I’d like to hear from some Republicans to make whatever I write more balanced.”

“Oh that’s very true, and we certainly don't want only their voices heard! I tell you what, give me your phone number and I’ll try to set something up with him in the next few days. What
does your calendar look like?” She asked me, looking at her computer monitor.

“I’m free to meet anytime any day that works best for him.”

“Well his schedule is pretty booked solid, to be honest, but we might be able to squeeze you in this Friday. Would that work?”

“Absolutely!”

“It’s nothing definite, but I’ll see what I can do. Write down your number and I’ll let him know you stopped by—we certainly want both sides to be heard!”

“Definitely, and I know this is a sensitive issue, so I’d really like to hear from everyone. Everything he says is confidential, and this is for academic purposes—I’m not a reporter and won’t put anything he says in a newspaper or anything like that.”

After thanking Representative Ramsey’s assistant, I left their office suite and went to meet with Jim, the lobbyist I had gotten to know during my time in Atlanta. He had been helpful in providing me a list of legislators he knew would talk to me and had given me background information about how HB 87 passed. According to Jim, HB 87 passed as an accident because other legislation on their agenda related to taxes and health insurance failed to materialize in a passable bill. Although Republicans campaigned on HB 87, Jim claimed they never intended on passing it because of strong opposition from agricultural leaders, but once other bills failed, they needed to pass legislation to appear productive to voters. He further suggested that political maneuvering between the bill’s sponsors, Matt Ramsey and Chip Rogers, led other Republicans to vote for the bill.

“Matt Ramsey is a powerful figure…he controls a lot of the party’s lines on issues,” he explained. As cosponsor of HB 87 and central Republican leader, I had hoped to meet and speak

27 Jim and all other names in this chapter except for DA King and Stacey Abrams are pseudonyms to protect the identity of this participant.
with Ramsey and get his perspective on the law and the impetus for it. Speaking to his secretary seemed promising and would hopefully provide a narrative other than the ones I had heard. When I met up with Jim the day I saw Ramsey’s assistant, he immediately asked if I had talked to Ramsey, and I told him no.

“Who else is on your list of people to talk to for your study?” he asked.

“Right now I really want to talk to anyone who had anything to do with HB 87.”

“HA! Good luck. Republicans aren’t going to speak to anyone about that.

“Why not?”

“Because they’re embarrassed and it’s not politically favorable right now. [National] Republicans just lost the Latino vote [in the presidential election] and here’s Georgia, home of the anti-immigrant laws. It doesn’t look good for them.”

“It’s funny you should say that—I either get rejected for an interview or they ignore me.”

Nodding, Jim frowned. “They’re not going to talk about this; party leadership won’t let it happen.”

“Well I’m hoping I have an in—we’ll see if it follows through.”

On Thursday afternoon of that week I received a phone call from Ramsey’s secretary informing me that the Friday meeting would not work for him.

“I’m going to try to reschedule though before session ends and I’ll let you know what happens, but it’s a busy session so I don’t know if he’ll have time to meet with you,” she explained.

The obstruction I experienced in trying to meet Matt Ramsey mirrored other ways Georgia Republicans ignored my efforts to speak to them. Republican legislators either rejected interview invitations, never responded to emails and phone calls, or had assistants who
continually informed me of their inability to meet with me due to busy schedules while assuring me I was not being ignored. As one assistant insisted,

“He’s got a law practice, a wife, plays baseball, and has a little one at home, so he’s not ignoring you, he’s just busy.”

Despite never meeting with Republican legislators, I was able to interview Democrats, including House Minority Leader Stacey Abrams. I had never intended on insuring equal representation of political parties in interviews, but instead hoped to speak with supporters of HB 87 and those who opposed the law. This effort effectively categorized interviewees in one political part or another as cosponsors and public supporters of HB 87 were all Republicans and the vocal opposition to the law were Democrats. Of the most vocal Democrats, Leader Stacey Abrams, was most willing to share a perspective about immigration laws in Georgia and immigrant policing.

Leader Abrams has been described as a political “up and comer” among Atlanta progressives. She is the first woman to lead a political party in the Georgia General Assembly and the first African-American to lead in the Georgia House (Friends of Stacey Y. Abrams 2014). Trained in sociology, public affairs, and holding a JD from Yale Law School, I was unsurprised to find Leader Abrams engaging, eloquent, and quick to describe the social consequences of public policy. As House Minority Leader, Abrams sets the political discourse for the Democrats in the Georgia House of Representatives, making her an ideal gatekeeper to insight regarding legislators’ opinions from her own party. When I asked her about HB 87, Leader Abrams contextualized Georgia as a state with a deep history of racial and class-based divisions, further subdivided by urban and rural settings that have strong economies and require immigrant labor.
You have a deep agricultural history, which has led to the need for immigrant labor, but there’s always been a little bit of hostility about it because immigrant labor basically dispossessed sharecropper labor. We’ve got this complicated history of race and class that has always been part of the state, and then you add to that the fact that if you’re in the north the immigrant labor is used for chicken processing, and if you’re in towns or in tourist areas it’s used for restaurants. So in economic boom times, things are fine because you have this mutual coexistence because [immigrants and none immigrants aren’t] fighting over anything.

Further tying together labor, rural and urban divides, the state’s economic situation, and immigration, Leader Abrams explained the rise of anti-immigrant sentiment and immigration laws passing the state legislature being connected to Georgia’s economic decline, bad policies, and immigrant scapegoating rooted in a history of racial discrimination.

The genesis of this antagonism isn’t anything new or illustrative of some zeitgeist taking over the state, it really is reflective of the cycles of history, which are that when you have lack of anything or [face some type of] a challenge, you always blame the thing that doesn’t look like you, and to the extent that you can create an alien presence and dehumanize it than that becomes much more aggressive.

Linking processes of dehumanization to economic concerns, Leader Abrams added, “You add all that together with the fact that North Georgia in 2010 faced a dramatic economic decline, and that was the hub for a lot of the economic success for the state. So if you look at the map,” Leader Abrams said to me, pointing to a map of the state on her wall, “North Georgia is about one third of the map,” she said, gesturing at the top of the map. “They were producing all of the couches and carpets and all of the furniture and everything that was going into the housing boom

28 Scholars like Cindy Hahamovitch have also drawn parallels between sharecropping, slavery, and guest worker programs by describing how guest workers entered places with rigid Jim Crow laws and were sometimes subjected to harsh physical punishments. See for example, Hahamovitch, Cindy. 2003 Creating Perfect Immigrants: Guestworkers of the World in Historical Perspective 1. Labor History 44(1): 69-94.
that was fueling Georgia… and they were hiring a lot of undocumented persons to do the work. When it all collapsed,” she continued, referring to the national housing market collapse, “you suddenly had to explain why we had all these Latinos, and to a lesser extent Asians, but mostly Latinos, living in these communities that were predominantly white and never really had to coexist peacefully with other communities.” For Leader Abrams, the genesis of laws like HB 87 stemmed from an economic decline that made use of available immigrant labor, but when the economy worsened, the racial composition changes in areas that accompanied labor changes resulted in heightened anti-immigrant sentiments expressed in economic terms. “Suddenly [elected officials] had to explain why there were no jobs available to all the people who elected [them],” she added. “So despite having every major corporation saying that [HB 87] is a bad idea, despite having every national figure we could muster talk about why this is terrible…the political power center had to explain why their economy was collapsing, and it was either the Republicans’ fault or immigrants’ fault. They picked the immigrants.”

Economic scapegoating of immigrants further coincided with critiques of the federal government’s alleged inability to control costs of entitlement programs and failure to appropriately respond to immigration concerns. “The articulated reason was cost,” Leader Abrams explained, “and the articulated reason was we had to act because the federal government didn’t.” Other legislators I spoke to also mentioned the failure of the federal government to act, and Leader Abrams, like others, felt this was a reasonable argument. “I think [the federal government issue] might be legitimate except that state laws have never served to actually stop or thwart unlawful activity when it comes to immigration.29” Similarly, immigration laws that

29 Echoing Leader Abrams, other legislators expressed similar ideas that Georgia’s immigration laws like HB 87 were in response to the federal government’s failure to enforce federal
passed in other states largely drew from a rhetoric of federal government failure to justify state legislation focusing on immigrants (Rodriguez 2011). Despite justifying laws like HB 87 as economically necessary and required at a state level because of federal inaction, in some locations, like Georgia, business leaders have argued immigration laws have contributed to economic hardships.

When I arrived in Atlanta I attended a meeting called “Forging Consensus,” which brought together a group of political conservatives to discuss immigration reform. The event featured Alberto Gonzales, US Attorney General during the George W. Bush Administration, and talks from academic researchers, attorneys, chamber of commerce representatives, law enforcement agents, agricultural industry representatives, and politicians, who described the importance of immigrants in Georgia. Some of the speakers, including the representative from the Georgia Restaurant Association, discussed the negative economic impact of HB 87, arguing it resulted in fewer immigrant workers to fill service economy jobs (Georgia Restaurant Association No Year; Trevizo 2012). When I asked leader Abrams if Georgia legislators would change HB 87 because of economic data, she argued that changing the law would be politically difficult. “There is no political will to fix it because you have to admit out loud that it was a mistake,” Leader Abrams said. “Let’s take the IERB as an example,” she continued. “The largest
noncompliant sector is agriculture and it’s for a reason. What we’ve done is essentially nullify our own laws through our agency inaction...a great deal of the law was nullified by the Supreme Court decision, then more of it was nullified simply by inaction...” The result, Abrams explained, would be an unenforceable law. “Ultimately what we will have is really, really awful law on the books but very little enforcement, which I think is the intent. You know, you got the bang for the buck which is in an election year you got to say that you hated immigrants but in reality hurt the economy, and now will do very little to actually enforce it.”

Thinking of anti-immigrant activists like DA King, who would continue to push for compliance if HB 87 were not enforced, I asked leader Abrams what the outcome would be of such complaints. In her response, she suggested the core issue of immigrant policing: race-based politics:

> We lost $3 billion and despite the fact that there isn’t aggressive enforcement, you still have the reality that we’re not getting the same level of migrant labor for farms that we used to get because they’re afraid to come here because they don’t understand that were not going to do anything about it anymore. I don’t think the migrant farmworker network has let people know that Georgia is safe to return to yet. But the zeal, the zealotry that DA King and others bring to this issue will not go away because there’s the political dynamic which says this is a good way to get elected and then there’s just the true xenophobia that says that these people are somehow evil and unworthy and that doesn’t disappear.

The political expedience of immigrant scapegoating points to how race-war logics can operate and gain political traction, resulting in a policy that may undermine a state’s economic interests.

**Tracing Policies to Anti-Immigrant Activists**

In addition to Leader Abrams, other legislators I spoke with also discussed xenophobia and racism, pointing not to just state legislation, but county ordinances restricting undocumented immigrants from certain housing. As one legislator said to me, “Cherokee County back in 1999
tried to pass a law focusing on rentals. They wanted to not allow rental units to people without documents.” The same legislator identified DA King and his organization, the Dustin Inman Society, as one of the largest anti-immigrant groups in the state.

“You know the name of the Dustin Inman Society is taken from a young man who was hit and killed in a car crash, right?”

“I had no idea.”

“That’s where it comes from, and the person at fault was a person who was not legal in the country. So they took that mission, and again it was the right moment in Georgia to have that strong platform against illegal immigrants, and they followed through with several demonstrations, manifestations, rallies, and I think the epic legislation that they did was HB 87—[Representative] Chip Rogers, [cosponsor of HB 87], was the sidekick of DA King back then.”

Legislators, lobbyists, and activists often suggested DA King was politically connected to Republican lawmakers in Georgia. Jim explained that Chip Rogers and other Republican legislators used King as mouthpiece to reach a set of conservative voters connected to anti-immigrant and conservative organizations:

“He’s really radical, and he’s a gatekeeper to a bunch of groups, so they allowed him to voice ideas for legislation. He’s the official representative of FAIR [the Federation for American Immigration Reform] through his group, the Dustin Inman Society.” The Dustin Inman Society features a website full of content espousing an explicitly anti-“illegal” immigrant rhetoric and claiming credit for two of Georgia’s immigration laws: SB 529 (2006) and HB 87 (2011). The site also features lists of individuals and organizations allegedly “encouraging, assisting, and profiting from illegal immigration,” which includes local activists and is as far reaching to
include the Anti-Defamation League and the Ford Foundation (The Dustin Inman Society No Year).

Beyond being a response to activism by anti-immigrant leaders like DA King, HB 87 passed in part, according to one legislator, because the Republican party needed “feel-good legislation.”

DA King is a strong force behind this even though he had only a small number of people in comparison to ACLU and unions and Democrats and the whole shebang that encompassed the Latinos the Asians and the rallies and we had with over 5000 people on the steps of the Capitol. He was over in the corner with about 10 people rallying against us and we had over 5000 people. But this was feel-good legislation for conservatives to go back to their district and say ‘look how hard on immigration I am,’ especially for conservative white folks who say Latinos are taking over.

Ultimately this “feel-good legislation” has racial undertones and economic consequences, and this legislator, Like Stacy Abrams, this legislator, Representative Mack, noted that HB 87 harmed Georgia’s agricultural industry. “Agriculture is our number one industry—over $65 billion. Those were the first ones hurt; within the first 30 days of HB 87 being passed, they lost about $300 million. The forecast was they were going to be losing about $1 billion in about a year- or two-year span.” Mirroring comments I heard at the Forging Consensus event, the legislator added that the restaurant industry also felt negative impacts from HB 87. “The restaurant association came out strong opposing HB 87 because a lot of the people working behind the scenes at restaurants were Latino immigrants, so again there is going to be an immediate impact on the economy.”

Beyond harming the economy and despite its “feel-good” purpose to placate concerns of those with immigration anxieties like DA King, HB 87 further created a problem that plagued Georgia officials since it had gone into affect: professional license renewal. Speaking on this
issue, Representative Mack explained how HB 87 created what some legislators and lobbyists called “a bureaucratic nightmare” for the state.

That section [of HB 87] that says that if you’re licensed in the state of Georgia, everything that you renew you have to show your citizenship you have to show your legality of the country, the Secretary of State came out swinging saying that they don’t have the budget or the manpower to review all of the nurses, the doctors, the cosmetologists…Everyone that has to have a renewal of the license was backlogged because nurses were usually going 20 days and this is going to take about three months for them.

Another legislator commented on the licensing problems created by HB 87, adding that the Secretary of State’s office was unable to adjust to new provisions HB 87 created: “The Secretary of State’s office has been overwhelmed and they are not funded to handle this amount of volume so they complained.” Similarly, the legislator added that this affected all professionals with licenses and not just practitioners in health or esthetic fields “The insurance commissioners also complained because all of the insurance agents that have to get their licenses renewed have had to deal with obviously a systems backlog and clogs to facilitate this bill.” The licensing concerns from HB 87 inspired subsequent legislation championed by DA King and were discussed at IERB meetings.

The IERB

When HB 87 was created, it established the IERB as an oversight board comprising members appointed by the Governor and Lieutenant Governor. The IERB holds ad hoc public meetings I attended while in Atlanta and reviews complaints any person can file that allege noncompliance with HB 87. In creating the IERB to supervise broad efforts of compliance with the law and promoting police as immigration enforcement agents, HB 87 created broad and overlapping systems of surveillance. Surveillance efforts are ostensibly maintained structurally though the IERB and dispersed locally through numerous spaces with police officers as agents
given the task to assess immigrants’ legal status. These provisions were further enforced passively through restrictions in types of social services and assistance provided to undocumented immigrants.

The IERB was a surprise addition to HB 87 and has no legislative history or documented public debate about its creation (Kuck 2011). It serves to hear complaints, investigate them, and take action appropriate to respond to complaints. It is empowered to make its own rules, subpoena documents, and place witnesses under oath for testimony regarding alleged violations of HB 87. The purview of the board’s enforcement includes ensuring public agencies and employees properly enforce the use of E-verify, ensuring compliance with state sanctuary policies, and ensuring use of the SAVE system, a program verifying immigration status for public benefit applications. While conducting fieldwork, I attended the IERB’s four public meetings. DA King was present for three meetings and filed complaints that were discussed in all of them. King was responsible for a series of complaints brought against Georgia’s Department of Audits (DoA), Department of Community Affairs (DCA), and other state agencies and local municipalities, alleging one municipality was a sanctuary city for undocumented immigrants and that DCA and DoA failed to prohibit undocumented immigrants from receiving state benefits.

Meetings for the IERB were usually announced only two weeks ahead of time and were not widely publicized even though they were open to the public. I learned about meetings from GIRRC listserv emails notifying me of the time and date of the meetings, which were held in a legislative office building across from the capitol that housed offices for legislators, including Stacey Abrams, and spaces used for events such as the ACLU’s “By the People” legislative days, at which the ACLU provides suggestions for citizens to give talking points to legislators. The board consists of seven members, all of whom have some affiliation with the Georgia
Republican party. Board members currently include: attorney Ben Vinson; former journalist Phil Kent; Government Relations consultant and Georgia Department of Veterans Service board member Shawn Hanley; Boyd Austin, mayor of Dallas, Georgia; Coweta County Sheriff Mike Yeager, attorney Robert Mumford, and Colquitt County Commissioner Terry Clark. Republican State Senate hopeful John Kennedy replaced Robert Mumford in the one of the final meetings I attended.

Phil Kent was a particularly controversial choice for the board; one legislator I interviewed claimed Kent had connections to hate groups and nativist organizations, saying, “oh he’s evil.” Kent’s appointment to the IERB prompted action from the Southern Poverty Law Center (SPLC), which charged Kent was a “Hate Group Leader,” citing his roles as member of Americans for Immigration Control (AIC), Executive Director of Americans for Immigration Control Foundation (AICF), and board membership of ProEnglish, a national organization advocating English as the official language of the United States (Beirich and Southern Poverty Law Center 2011). Kent’s, and possibly other IERB members’, ties to anti-immigrant organizations is alarming since he serves on a government board with authority to sanction agencies and municipalities for not complying with HB 87. Kent’s and other board member’s connection to DA King is similarly questionable. Members of the board were often friendly with King, particularly Phil Kent, who displayed at more than one meeting a sense of admiration for King by pushing for him to be able to address the IERB and ardently taking his positions during meetings.

Since attending the first IERB meeting after arriving in Atlanta, I noticed all the meetings had focused on complaints King had filed. These complaints included claiming the city of Vidalia violated Georgia’s sanctuary city policy and that the DCA, DoA, and hundreds of other...
state agencies were not compliant with Systematic Alien Verification for Entitlements Program (SAVE) requirements put in place by HB 87. In several of the meetings King referred to himself in ways that suggested closeness with legislators, once describing what he saw to be his hand in drafting HB 87: “In 2009 we altered Georgia code (and I say ‘we’ because I’m regarded as furniture around here) to ensure applicants for entitlements be checked against the SAVE program for eligibility.” The SAVE program was one of DA King’s largest concerns, arguing that lack of compliance with SAVE was costing taxpayers money through granting undocumented immigrants benefits. At one of the first IERB meetings, King explained what he saw as the rationale for passing immigration legislation.

![Figure 11: DA King staring at the photographer, Roberto Gutierrez, during an IERB Meeting.](image)

**Bringing Complaints Against Agencies through HB 87**

One of the IERB’s main functions was to ensure compliance with HB 87, and DA King made reporting compliance errors a personal hobby, if not full time job, for himself. At one
meeting I attended, he presented his arguments against agencies not complying with HB 87 and sought action from the IERB (Redmon 2012).

“All of the immigration laws are aimed at saving tax payer dollars and jobs,” King asserted in one IERB meeting. “The state of Georgia ranks number six in illegal immigrants, ahead of Arizona. We spend $2.5 billion in illegal immigration, so these laws were created to save dollars and jobs.” King asserted that under HB 87 all government agencies were required to file reports with DCA and DoA regarding their use of SAVE and E-verify systems. He argued that since agencies were not complying with these requirements, DCA and DoA were failing to comply with HB 87. This assertion ultimately led the IERB, at the urging of Phil Kent, to conduct an investigation on the DCA and DoA to assess whether the numerous entities under their purview were using the SAVE system when assessing benefit eligibility for applicants and the E-verify system when hiring employees. In a meeting where DCA and DoA representatives had to respond to the allegations against them, DCA Commissioner Mike Beatty and DoA Director Carol Schwinne appeared before the IERB and offered responses to King’s complaints and the IERB’s concerns. Beatty explained that the alleged noncompliance was due to not all agencies being aware of the requirements, and he appeared to try carefully not to upset DA King.

“Being a former legislator, I appreciate abiding by the law, and I appreciate the enthusiasm of people like DA King,” he cautiously began one statement at a meeting. In that statement, Beatty claimed that although not all of the DCA institutions are complying with the requirements to check entitlement applications against SAVE, he offered that he would work with the Governor to ensure all agencies were in compliance by the end of the year and educate agencies, explaining it was “a culture change” since HB 87 passed. “If we messed it up, we messed up trying to do what was right,” Beatty pleaded. “We’ll do what we can to make sure
everyone complies with this. I think there are great people in this state and, lord, we just have to get the information out! We want to make sure people are using SAVE the right way for those public benefits.”

In an attempt to explain potential problems with getting all entities compliant, Boyd Austin noted that some government agencies are not connected to the internet, and smaller towns especially may have trouble with internet access, so it may take time before 100% compliance is possible. King, who had been standing during Beatty’s presentation, interrupted Austin and asked be recognized to speak.

“I enjoyed Mike’s presentation about his office not being in compliance with the law, but the size of the city is not relevant,” he asserted.

Ben Vinson, nodding to King, said he appreciated King’s comments, and Phil Kent charged that the board needed to take action. “We need to make an example out of agencies not complying with the law!” he exclaimed. Boyd Austin, in a more reasonable approach to understanding claims of noncompliance, suggested that there was more to the situation.

“I don’t think it’s as willful as people think it is,” Austin interjected, stating that agencies and municipalities are not likely to be willingly noncompliant with the law.

“But we don’t know that!” Kent retorted. Ultimately the board agreed to investigate DCA, allow the agency more time to understand who is in compliance and who is not, and wait for a report to explain the situation. This decision annoyed King, who scoffed loudly behind me.

The DoA had a less difficult time than DCA responding to noncompliance changes. In addressing the complaint against her agency, Carol Schwinne explained HB 87 required her department to develop a website that explained all governments notify her office about contracts to ensure contractors were using E-verify. Since “governments” are defined as any entity
receiving public funding of any kind, her office expected to hear from a very large number of agencies. When the deadline to deliver this information arrived, there were 1,170 governments that did not comply, prompting her office to send letters requesting information. The information request was to assess whether or not reporting information was needed; any agency without paid staff would not need to report, so her office felt the request for information was an appropriate way to determine who should and should not be reporting. Her office received 600 responses from governments, and there were 570 governments that have not provided the information. Most of the governments on the list, she suspected, do not have employees, so they were not required to provide the information the DoA requested. Through questioning from the IERB members, Schwinne explained that the list of governments required to provide information can change every year since it includes school boards, development authorities, and other potentially changing organizations that do not have employees but can be staffed by volunteers, and that her office was attempting to figure out how to deal with the challenges associated with frequently changing circumstances. After Schwinne’s explanation of alleged violations, Vinson invited King to respond to Schwinne and the DoA.

Rather than rebutting Schwinne’s points in his response to the DoA, King refocused on DCA and Mike Beatty, especially. “The spirit of the law was to protect jobs,” King began. “It’s important for the board to know that SB 529, passed in 2006, originally required all public employers to use the E-verify requirement. HB 87 went into effect in July 2011; only then did an exception get created where employers without staff did not have to use E-verify. I happen to know that there was never 100% compliance from the 2006 law…I have spent my own money traveling around to different county commissioners and the like, and they did not know there was a law passed requiring them to use the SAVE and E-verify program. I heard from DCA that
they’re in violation and ‘just work with us,’ and I want to know under what laws as citizens we can have the same treatment. I’ll be filing papers with the Attorney General the following day to pursue civil action against DCA since the board is not taking action.”

Vinson thanked King and asked Beatty about DCA’s compliance efforts, and Beatty explained DCA was “working on it.” Phil Kent, watching DA King, who stood in the back, quickly accused DCA of failing to comply with HB 87.

“But you really aren’t in compliance!” he asserted.

Beatty promptly asked for assistance from someone accompanying him, who stood and firmly rebutted Kent’s accusation. “We’re in compliance with HB87 and with E-verify, so to say we’re not is not correct.” Ultimately the board agreed to allow DCA more time to address the complaint King brought and did not settle the DoA affair. By the following meeting, which occurred three months later, DA King had withdrawn his complaint against DoA but continued his complaint against the DCA.

**Responding to King’s Accusations**

At the follow up meeting, a DCA division director, John Turner, addressed the board about King’s complaint. Turner explained that the DCA has worked to advance compliance efforts and provided a written response to the IERB regarding DA King’s complaint. He added that the DCA is changing the internal eligibility assessment system to meet SAVE requirements, which would address the alleged problems with DCA’s public benefits eligibility system described in DA King’s complaint, and that some agencies were not initially clear of their responsibilities under HB 87. Because of the changes DCA has made, Turner asserted that DCA addressed the complaint. This explanation was not satisfactory to King, however, who railed against DCA and state agencies for not being in compliance with all parts of HB 87.
“Ignorance of the law is not an excuse for not complying with the law,” he railed. “Georgia has more illegal immigrants than Arizona, and every illegal immigrant takes a job, a benefit, or a service from someone here legally. Why are we ignoring the law meant to protect Georgia jobs?” In a dramatic gesture of change, King called for Mike Beatty’s resignation, claiming that someone aware of laws and not needing to be coerced into compliance through the threat of a complaint should be running the DCA. He then expressed surprise that the board had not used its authority to place people under oath and make them testify about his complaints.

Upon hearing King’s tirade, Phil Kent demanded an evidentiary hearing, but no one was entirely clear on what. Around me, reporters looked to each other trying to understand what was happening.

“Are you following any of this?” one asked.

“No,” another responded, laughing. All that was clear was that DA King was angry, Phil Kent was motivated by King’s anger, and the board was moving to take some type of action against the DCA.

Ultimately the board agreed to have a hearing, and Kent asserted it must be done expeditiously. When the board agreed to have a hearing 30-45 days after the meeting, Kent invited DA King to address the board, adding that perhaps legislators may need to alter HB 87 to attend the hearing. King offered to recommend to the board which legislators should attend and would be amenable to changing immigration laws. He specifically added that the language needed to be altered in section 5036.1 (without mentioning a law) so that entities that do not provide a public benefit are clearly required to file a report making that fact clear. King again asserted that the DCA commissioner should resign, and volunteered to be hired for the job because he claimed he already did it for free. Kent responded by saying he would like to hear
more about legislation recommendations and which legislators would be amenable to making changes needed to immigration laws, and DA King said he would provide more recommendations later. Turner, seemingly frustrated and incredulous about what was unfolding, explained that the DCA is not a regulatory agency, and that DCA can only send a notice to entities informing them of their need to report under the law.

“DCA wants to be in compliance but has no means by which the agency can require public entities in Georgia to register and report their public benefits programs.” Despite this explanation, no changes in action were made, and the board adjourned until the final time I saw them meet.

**Non-Compliance Accusations Continue to be Heard at the IERB**

During the final IERB meeting I attended, connections between DA King and the IERB board members began to crystalize for me. Before the meeting began, I made my way through security and into the elevator. As I exited the elevator, I saw Phil Kent approach King, who was standing with a group of people. Kent smiled, and called out to King.

“Hey, I’ve seen you on TV!” Kent exclaimed, suggesting King had celebrity status. King laughed and the two of them began to talk with the three others accompanying King before making their way into the hearing room where the IERB met. During this meeting, King withdrew his complaint against DCA, claiming the current law would not allow for additional sanctions. He then requested the board focus on a complaint he filed eight months prior, received at the first IERB meeting I attended, in which King was absent, claiming the board had not fulfilled its obligation to respond to complaints in 60 days. Vinson responded by explaining the IERB was staffed by unpaid volunteers and was only required to review complaints internally.

---

30 As stipulated by HB 87, section 20.
within 60 days and did not have to take action within 60 days. Phil Kent pressed King’s point, and Vinson, seemingly annoyed, explained the challenges in addressing the complaint, which listed hundreds of agencies allegedly not complying with HB 87.

“A shotgun complaint against 600 entities proves problematic for the board; there is no staff, and our budget allows money for staff but should be used for court reporters and subpoenas.”

Kent responded by insisting the board take action. “These are entities that refuse to report to the Department of Community Affairs and we should choose a few, 5-10, to go after and make an example to show this board has some real teeth in enforcing the law!”

One of the women accompanying King, Leann, a leader of Georgia Conservatives in Action, stood up during the meeting and insisted the board take some action, suggesting they start with agencies not complying by alleged chronological order of noncompliance. Following Leann, King asserted the board was failing to do anything to change the current situation and said he was stunned by the attitude of the chair saying the IERB would not investigate 600 agencies:

I remember when I filed my complaint against 1,200 agencies for being in violation of the E-verify law, I remember vividly when the sheriff set that aside and said ‘we are not going to address that, there are too many offenders.’ I am now being told that 600 agencies in violation of the SAVE regulation for public benefits is too many, and now we’re trying to decide how many isn’t too many…I want to make it clear to the public that the laws on the books agree to us having sanctions were being ignored and clearly nothing is happening here today that will change that. I am completely stunned by the attitude of the chair and whoever on the board agrees with the fact that because there are 600 entities or agencies on the list that are clearly in violation of the law that it’s too many to work for. If the action is to make the citizen who is aware of the violators find the time and money to itemize every
separate written complaint, I don't believe that is in the spirit or intent of the law.

IERB member Shawn Hanley directly responded to King. “It’s just...you can or you can’t—the reality is that there are 600. We’re the investigators--we’re it, that’s just the reality...Nobody is more incensed about the degree of law breaking across this country and across this state when it comes to illegal immigration,” Hanley claimed, seeming to express sympathy with King’s frustration. “It sickens me to a high degree that we go through this every day on our roads and everything else,” he added. “But DA, you have to take a look at what we’re doing. We’re doing the best we can, the chairman is doing the best he can—unfortunately there is a procedural issue we have to take care of. We want to make sure this board—we want to go after every single agency we can—that’s the issue…” Further suggesting the practical problems of examining how complaint agencies were with HB 87, Hanley added: “We’re not going to go bouncing around to 600 agencies because it’s not going to be a very good investigation, sorry, but it’s not. I’d appreciate you to rethink it and say “how can I get the most out of the board? How can I drill down and get 10?’’ This is an opportunity for you to work with us.”

With Hanley’s direction, the conversation refocused on the need for due process and the requirement of specificity in complaints rather than large blanket accusations claiming hundreds or thousands of agencies are not complaint with HB 87. After tense dialogue between King and various board members, one women accompanying King, Leann stood up and accused the board of failing to address existing laws. “I don’t understand why we’re passing laws if we’re not going to hold people accountable for what they do!” Leann exclaimed, in a heavy southern accent. “If we are allowing mass groups of people to just simply ignore the law, why are we making them in the first place? This is ridiculous, I mean we’re supposed to be a state of laws, and we’re supposed to obey them however you have to obey them!” Becoming increasingly
animated, Leann continued to suggest the board’s request for a reasonable number of agencies to investigate was unnecessary. “I can’t imagine singling out one or two, I mean either you investigate every one of them and prove them right or wrong or just forget it! Let’s just don't even have law! Let’s just go back to the way it used to be.” Shifting from anger to desperation, Leann then pleaded with the board. “Y’all we’re losing this country, and we’re losing it a lot because of how we’re handling illegal immigration, and I am just beggin’ you--take these things seriously because they are very serious.” Sitting down next to King, Leann looked at him and they smiled to one another.

Responding to Leann, Shawn Hanley thanked her for her comments and suggested he knew she and DA King outside of the meeting. “Leann, thank you for coming—I respect all the work you’re doing…Look, you got a friend up here, DA knows he has a friend up here, we’re all on the same side, that’s why we’re here.” More than “being on the same side,” Hanley suggested he was a similar type of activist to King and Leann: “I’m not a lawyer; we’ve got plenty of them up here, and they’ve done a good job making sure the legal pieces are pretty tangled. Me and the Sheriff are the “out of control grassroots nutcases,” as they call us in the media, sometimes, so we’re on your side, and we’ve got to selectively make sure we get the ones that are really overstepping the law.”

In a fiery discussion about how to handle King’s complaint, DCA representatives asserted they did not have enforcement powers to demand noncompliant agencies become compliant, and Vinson explained the board could not investigate all 600 entities, suggesting King choose the “worst offenders” and re-file his complaints. Leann and others accompanying King offered services such as printing letters and one man, Todd, suggested the board enact a bounty hunter system offering rewards to citizens who identify the noncompliant agencies. King
requested the board ask the governor for more funding to carry out investigative procedures, and Kent agreed with the idea, asking about their current funding.

“We have the ability to be reimbursed per diem for meetings, get reimbursed for any court reporter, or transcription,” Vinson explained, attempting not to detail how much money in particular the board had.

Carol Schwinne, sitting in the audience, explained the board has $20,000, prompting Kent to say the board could ask for more money to start traveling and Kent requested a motion for the board to at least double the current budget for enforcement purposes. Schwinne explained that the Department of Audits could not just move money and the appropriations committee would have to do this. This struck me as deeply ironic; the IERB proposed its publically-financed budget for ensuring undocumented immigrants do not receive public funds be enlarged.

In a time when anti-government rhetoric was particularly popular at a national and state level, activists and IERB members looked for ways to extend funded bureaucracy but only to ensure undocumented immigrants do not receive any type of publicly financed benefit.

As the board wrapped up its meeting by discussing its finances and the need to get more money from the state to conduct investigatory work, another immigration bill, HB 125, simultaneously passed in the House—a bill DA King heavily championed.\(^{31}\)

**HB 125 Passing**

While sitting in the IERB meeting, I learned about HB 125 passing through the television screen displaying the Georgia General Assembly meetings and debates in the board room where

---

\(^{31}\) King publicly voiced support for the bill and posted Facebook messages on various anti-undocumented immigration groups’ pages urging people to call legislators and voice support for HB 125.
the IERB meeting took place. Once the meeting adjourned, I asked Jim what he thought the implications of HB 125 passing were.

“All we can hope now is that the Senate doesn’t adopt it. They’ve got their own version of the bill, SB 160, and we can hopefully change some minds about it and get it at least so people can turn on utilities and rent apartments.” Both SB 160 and HB 125 proposed to alter Georgia law to require a Georgia-issued form of identification to enter government buildings and to be considered the only official form of documentation for business and governmental purposes. The implications of these laws translated to prohibiting anyone with a passport outside of the US and lacking a Georgia driver’s license the ability to open bank accounts, rent apartments, or turn on utilities. Acting on concerns from GLAHR and other groups about the utility implications in particular, Jim spoke with legislators, business representatives, and organization leaders to push for changing SB 160 and HB 125 so they would not bar undocumented immigrants’ from being able to obtain utilities. “I just can’t believe they’re still doing this stuff—did they not see the results of the last [presidential] election?! It’s going to come back to bite them later.” Although the 2012 presidential election resulted in public discussions Latino voters being a large portion of the electorate and immigration concerns being important issues to Latinos (Pew Hispanic Center 2012), the Georgia legislature ultimately passed SB 160. By the time SB 160 was signed into law, it was altered to remove utility restrictions and resulted in banning passports to be considered as secure forms of identification in certain circumstances, such as applying for public benefits.

Prior to the bill passing, GIRRC organized a group of people to attend a legislative review hearing to comment on the need to amend the bill. On the day of the hearing, I went to the Capitol, but when I arrived to the basement room where the hearing was supposed to be held,
no one was present. I want upstairs to find Jim frantically walking around talking on his cell phone. I asked Mateo, a GIRRC member there for the hearing, what was going on.

"They're about to adjourn until next week," he said. "That'll be a nice break—today is Wednesday and they will start again next Wednesday." As Mateo and I walked down to the elevator bank to make our way to the hearing room, we met an ACLU attorney also planning on attending the SB 160 hearing. When we entered the hearing room, we noticed handouts for legislation unrelated to SB 160 and two young.

"Is this the room for the SB 160 hearing?" Mateo asked.

"Yeah," one of the sleepy-eyed staffers barely answered.

"Oh, that hearing has been canceled," the other staffer said, as he began placing legislative handouts on the tables.

"Oh, sweet!" The first staffer responded, walking out of the room so I could see his name tag and noticed he was Senator Ramsey’s intern.

"Yeah the meeting was canceled but I didn't see anything about it being rescheduled on the agenda," the other staffer added.

Mateo asked if there was any additional information about when the hearing would be rescheduled.

"I don’t know, man."

"Thank you very much," Mateo said, as we walked out of the room.

"Fuck! Fuck, fuck, fuck, fuck, fuck! We got to call everybody and tell them that this thing is canceled." Mateo and I went upstairs to the ground floor of the Capitol and walked outside to begin calling GIRRC members to notify them the hearing had been canceled. I met up
with Jim later in the day to find out why the SB 160 meeting was canceled, and we rode down the elevator together to the reach the back exit of the building.

When Jim and I found a place to sit, I asked him about the SB 160 meeting.

“I knew the meeting would be canceled that so that they could reschedule it and hope that not as many people could attend. They knew that we raised awareness about the bill so now they’re going to reschedule and find time when not as many people can make it.”

Jim and I then discussed legislators I could interview and he again told me it was unlikely that republicans, including Matt Ramsey and other co-sponsors of Georgia’s immigration laws would speak to me. “If you were from Fox News,” Jim laughed, “then maybe you’d have a shot!” Ultimately I never interviewed Matt Ramsey or any Georgia Republicans—all of them denied my meeting requests.

**Discussion**

The IERB meetings, interviews with legislators, and other participant observation experiences in the Capitol point to policymakers’ rationalizing immigration legislation like HB 87 through themes of economy, race, and governmental authority. In interviews with legislators, economic scapegoating surfaced as a major explanation for why laws like HB 87 passed. Stacey Abrams and other legislators suggested that part of the rationale for passing HB 87 and its predecessors, HB 2 and SB 529, was economic scapegoating of immigrants. In speeches to the IERB, DA King similarly explained economic reasons behind Georgia’s immigration laws. Although there may have been some economic impetus behind immigration laws, this explanation fails to capture the entirety of the rationale for laws like HB 87 and specifically ignores racial notions of otherness that informed law.
Racial paranoia and concerns over losing the “whiteness” of specific parts of Georgia offers another explanation for why laws targeting undocumented immigrants proliferated across the state and included local enforcement tactics that have led to charges of racial profiling. Unlike immigrant settlement patterns in other major metropolitan areas, immigrants in Atlanta settled predominately in white suburban areas instead of the city core (Odem 2008). The suburban settlement pattern and the rapidly increasing number of Latinos arriving to the Atlanta area resulted in racial politics in which predominately white legislators, local government officials, and suburban residents responded to demographic changes enacting a series of laws and ordinances to restrict Latinos’ access to housing, education, health services, and transportation (Browne and Odem 2012). These ordinances were passed under the guise of restricting “illegal” immigrants’ access to housing and social services, but the “Juan Crow” laws targeting undocumented immigrants affected all Latinos (Browne and Odem 2012).

Political efforts to restrict Latinos’ mobility into suburban Atlanta and access to social services demonstrate anxiety over losing the “whiteness” of the area. Immigrants and organization leaders also considered the racial implications of immigration laws; Inés and many of the GLAHRiadores explained they felt policymakers targeted Latino immigrants due to racism, and Inés even colloquially renamed the Latino legislator, David Casas the Anglicized name “David Homes” to comport with her racialized logic of legislators targeting Latino immigrants. Laws like HB 87, and immigrant policing initiatives generally, demonstrate efforts to uphold racial inequalities through legislation and police action (Roberts 2007). Just as Dorothy Roberts writes of the criminal justice system and African Americans (Roberts 2007: 263), police terror and legislation targeting immigrants are ways to support white supremacy.
Evidence supporting both racial and economic logics for legislators passing immigration laws like HB 87 suggests a biopolitical “race war” logic—blaming immigrants for failed policies and high unemployment and therefore allowing their “political death” and economic failure in order to support the success of white populations (Foucault 2003). Moreover, the race-war logic can be understood as way of supporting neoliberal ideology. Rather than serving a political economy of capital production or simply putting one group against another, the race-war logic of HB 87 serves a broader political economy of shrinking the state through asserting hostile forms of entitlement eligibility. By explicitly determining who cannot receive state-provided resources, laws like HB 87 extend efforts to reduce state services and demonstrate that the state will not provide resources to certain populations. In this respect, the race-war logic suits neoliberal ideals of shrinking state services because in determining who is ineligible for entitlements the state is able to refuse access to specific services and thereby reduce the number of overall people reliant on it for specific needs, diminishing its role in providing services and ostensibly creating new markets to replace the services it does not provide. These efforts mirror other ways of reducing state services by carving out exceptions in population eligibility for services, much like the ways neoliberal reforms of the 1990s created new exceptions for immigrants to receive social services (Ku and Matani 2001a).

In addition to serving specific neoliberal aims, laws like HB 87 also promote fear among undocumented immigrants even if they cannot be enforced, as I describe in chapters six and seven. The unenforceability of immigrant policing measures like HB 87 and its progenitors, such as Proposition 187 in California, point to how policies may be used to symbolically express social discontent, particularly a “dual hostility,” as Calavita calls it, “towards immigrants and government” (Calavita 1996a: 297). Immigrant policing efforts are thus ways of channeling
acceptable forms of nativism that purport to address economic and federal governmental failures. Moreover, Stacey Abrams’s claim that HB 87 will be an ineffective law that is unenforced but serves to promote fear among undocumented immigrants demonstrates how immigration laws targeting undocumented immigrants serve specific governing agendas. In later chapters, I describe how the governing agenda of immigrant policing is to use of fear in order to produce the ideal neoliberal citizen. Laws like HB 87 suggest ways to both manage populations, such as undocumented immigrants, and further manage individual behaviors through fear responses. As a technique of power focused on populations and individuals in deeply personal ways, however (such as limiting mobility and producing intense feelings of fear), HB 87 demonstrates how legislation instilling fear bridges the two poles of biopower Foucault describes—anatomy-politics and biopolitics, ways of controlling individual bodies and groups, respectively—into one specific technology of power.

Immigration legislation like HB 87 is therefore an efficient technology of power that accomplishes biopolitical and disciplinary objectives in one mechanism. This is not to say that immigration laws are the only types of governmental power (or techniques of power, generally) to connect disciplinary and biopolitical aims. While other types of governmental power may connect individual and population-level governance, I suggest that it is the efficiency of these techniques of power that may make them appealing to legislators as they can control a population through individual manipulation, potentially leading to some legislators’ goal for immigrants to “self-deport” (Kobach 2008), thereby possibly preventing demographic changes that may challenge white hegemony. Techniques of power targeting both the individual body and the population to address specific racial aims are best exemplified in this chapter by Leann claiming “we're losing our country, y’all” because of “illegal immigration” during the IERB
meeting, suggesting techniques to avoid “losing the country” are needed, such as stopping or reversing Latino immigration.

Just as troubling as Leanne clearly and disturbingly articulating race-war logics is the relationship between DA King, an activist against undocumented immigration, and the governmental authorities installed on the IERB. It is unclear by Phil Kent’s interactions with King and Shawn Hanley’s assertion that King and Leanne have a friend on the board (assumingly Hanley) whether King is social peers with IERB board members, if King has some type of unknown political power, or if King is a politically expedient pawn since he embraces neoliberal hegemony so fervently that he is activist for shrinking the size of the state and ensuring state benefits do not go to specific populations. Blog posts from Phil Kent indicate he and King are personal friends and “fellow activists” against “illegal immigration”32 (Kent 2004), raising questions about whose interests are most heard in political processes. Ambiguities regarding the IERB highlight the challenges in studying governmental power and more generally the idea of “the state” since the state comprises sets of actors with their own specific agendas who can be influenced by other actors. The IERB in particular demonstrates challenges in studying the state and governmental power because it is not clear if policy makers and IERB board members are taking direction from loud anti-undocumented immigrant activists like DA King, if policy makers have their own agendas and pay no attention to particular activists, or if there is constant collaboration and communication between government decision makers and activists like King. Additionally, if King plays a role in assisting with developing legislation, as Kent and King suggested when mentioning legislators’ names who would be amendable to

---

32 In this blog post Kent writes: “On Feb. 5, my friend and fellow activist D.A. King organized a demonstration at the Georgia Capitol building steps to protest the Bush amnesty plan in particular and unchecked illegal immigration in general.”
changing HB 87 to allow for sanctions against DCA, it is unclear how he obtained this role and is able to occupy it. The ambiguous ties between DA King, the IERB, and legislators supports notions of the state’s ability to prevent adequate study of itself (Abrams 1988).

Despite the difficulties in studying governmental power, however, analysis of specific types of power and governmental authorities’ actions is still possible, particularly with HB 87. Exploring lawmakers’ rationale behind such laws allows for considering how lawmakers create “citizenship projects.” Following Rose and Novas, citizenship projects are the way in which “…authorities [think] about (some) individuals as potential citizens [or non-citizens], and the ways they [try] to act upon them” (Rose and Novas 2005: 339). In Georgia, HB 87 was not only a citizenship project in terms of engaging a race-war discourse as a way of sanctioning political and economic harm to undocumented immigrants, but also as a way to improve political perceptions of the legislators. An immigration law with negative impacts on immigrants was politically helpful to the legislators who supported it under Stacey Abrams’s and Jim’s assessment, demonstrating how politicians can construct undocumented immigrants not just as racialized others, but as politically convenient and beneficial targets of policy. The effects of such policy can take on new life, however, as best demonstrated by the IERB, at the persuasion of Phil Kent, to extend funding to the board to carry out its mission. In this respect, the IERB undermines the economic logics of laws like HB 87 and further demonstrates the way in which laws like HB 87 are motivated by intentions related to race and population control.

Beyond being a convenient population to use for various political goals, the impacts of laws like HB 87 have had extreme impacts on undocumented immigrants and have shaped their lived experiences, as my experience with Inés traveling across Georgia demonstrated. These impacts are especially strong when combined in contexts like metropolitan Atlanta where Secure
Communities exists alongside 287(g) programs. Recent scholarship has demonstrated that the combination of state statutes and federal immigration policies working together in Georgia has altered immigrants’ mobility and lead to some immigrants feeling intense anxieties and a strong sense of fear (Stuesse and Coleman 2014), as I describe in the following chapter. Examining the individual impacts of immigration laws targeting an entire population demonstrates how citizen projects should not just be understood through governmental officials, but also those that are most affected by them.

Conclusion

Interviews with policy makers and participant observation experiences with lobbyists and the IERB point to how immigration laws can form a race-war logic to justify “political death” of immigrants, are efficient technologies of power combining anatomo-political and biopolitical endeavors, and can be understood as citizenship projects allowing legislators to make use out of immigrants for political gain. Participant observation experiences and attempts to interview legislators connected to immigration laws like HB 87 demonstrate challenges in scholarship aimed at understanding governmental power since roles of people involved in power processes are not always clear, and some policy makers behind techniques of power may prevent a robust scholarly analysis of governmental power by not participating in interviews or other data collection techniques. Despite these challenges, however, understanding the impact of immigration laws on undocumented immigrants requires examining the genesis of legislation used as a technique of governmental power.
CHAPTER SIX

“VIVIMOS AQUÍ CON MIEDO:” FEAR AND HEALTH-RELATED IMPACTS OF IMMIGRANT POLICING ON UNDOCUMENTED IMMIGRANTS IN ATLANTA

“Georgia has gone out of its way to be as unfriendly to the undocumented as possible.”
–Georgia House Minority Leader Stacey Abrams

“You leave the house in fear; you know a police officer can stop you.”
–Lupita, an undocumented woman in her 40s

Introduction

On an evening in March, I drove to meet Martina, who lived in an apartment complex near Doraville. The numerous dark brick buildings in the complex were likely built in the 1970s, but the chipping paint from the window encasings, broken windows in unoccupied buildings, and cracked steps leading to some of the buildings’ front doors made the all of the apartments feel older and in a state of disrepair. When I found Martina’s apartment, I met her and her friend, who began to tell me about difficulties they had driving and seeking health services. Martina, a woman in her late 30s or early 40s, has been in Georgia since 2005. Prior to moving to Georgia, she worked as a migrant farmworker, moving from Florida to Georgia and up to Michigan, picking tomatoes, onions, and cherries.

“We may have met before!” I joked when we met, explaining that I had met several migrant farmworkers in the Tampa Bay area while completing my master’s degree, and that I grew up in Michigan.
“Posiblemente,” she responded, smiling.

Although Martina had migrated for work in the past, one year she decided to stay in Florida because she was pregnant and a friend of hers suggested she move to Georgia. “After I gave birth to my daughter, my friend said, ‘you know, Georgia[’s climate] is like this, and there is work there in the shade,’” she explained. “Because I’ve been used to planting onions, cutting cherries and apples in Michigan, and doing other things in field, I was ready for a better job, and my friend told me there were better jobs in Georgia.”

Despite coming to Georgia for work and hoping life would be easier, Martina explained her life was actually complicated by police practices near her home. She lives in a neighborhood where police set up checkpoints near the corner of her apartment complex, and police activity has made it difficult for Martina to drive to work.

“They put up checkpoints here all the time and it’s hard to leave. I have to drive to get to work and up here at the corner, [by another apartment complex], they put up checkpoints. We know it’s better to not go through there or to just keep going the other way at night or in the afternoon. I can hear the roadblocks from here.”

From several informants I learned that checkpoints operate as road closures in which an officer stops every vehicle and asks drivers to show their operators’ licenses. Although I was never stopped at a checkpoint, I witnessed policing activities such as police cruisers sitting outside of Latino shopping complexes, neighborhoods, and churches. In describing checkpoints near her, Martina noted that she feels fortunate to have never been stopped by police, and she tries to avoid checkpoints even though she drives. “I drive, but it’s necessary to drive to work—to get yourself one place to another you have to drive. Up to now, thank god, police have never stopped me. But it’s scary because before if you got stopped you could pay a fine and someone
would bail you out, but now it’s not like that. Now you get stopped and you get deported.”

I asked Martina why she thought police put up roadblocks at the intersection outside of the neighboring apartment complex, and she explained police did it because of the Latinos living in the area. “Because I think they know that there are many Latinos that live there or a lot of Latinos go by there,” she explained, adding that she has become fearful of driving and has started altering how much she drives since checkpoints have become more common. Despite trying to drive less, however, Martina noted that driving was still necessary and could not be avoided entirely. “You drive in fear because you know the police can stop you…so now you only leave the house for what’s necessary, not like before when you could go shopping or go out just to spend time out. If you go out, it’s because you have to buy food or go to the store, or get a necessity. It’s not like it was before when you could go out whenever you wanted to.”

The constrained mobility Martina felt as a result of police practices was not limited to shopping or going to work. She, like many other undocumented immigrants I interviewed, said she would avoid seeking health services if she thought checkpoints were present, and continued to explain that she felt discriminated against in medical settings. As a DeKalb County resident, Martina is eligible for discounted health services at Grady Memorial Hospital, Atlanta’s largest public hospital that serves Fulton and DeKalb County residents. Yet despite being sick for months and feeling abdominal pain, nausea, and vomiting, Martina avoiding seeking medical care because she was concerned about the costs and did not want to drive the distance to a clinic. When her illness worsened and she finally went to a private clinic, she was diagnosed with gastritis. Martina’s gastritis did not improve with medication, and she returned to the clinic for additional tests, where she was informed she had hypothyroidism and required specialist care.

“When they figured out I had hypothyroidism, [the clinic I went to] gave me a list of
specialists but they were all private doctors. The doctor said I could go to one of these specialists and I said ‘but they will charge me $300 for a consultation!’” After speaking to a friend and family members about her health problem, Martina learned she could get care at Grady.

“So then I went to Grady, which is there for—well they help everyone there—they give you a Grady Card and it depends on your income [how much they will discount your care] and what you pay. So I got a Grady Card for six months and the card gave me 50% off what I would have to pay.”

Although Martina got the Grady Card that allowed her to receive treatment for her hypothyroidism and make payments based on her income, she felt discriminated against in the process. “When I got the card, a black woman helped me and she asked me for a Social Security number and drivers’ license, and I told her that I didn’t have a license or a Social Security number. She wouldn’t give me the card because I didn’t have a license or social security number! I can’t get a license!” Frustrated with her situation, Martina asked for an interpreter at the hospital and told him she did not have a license but had a Mexican passport. “He gave me a [Grady] card with the passport,” she explained. “But I’ll have to renew the card and have to carry my ID with me when I renew it.” Reflecting on why the interpreter gave her a Grady card but the African American woman would not, Martina felt as if she had been discriminated against because she is Latina. “It’s racism or something, or maybe because I don't speak the language, but the black lady didn’t want to give me the card. I showed her my passport and she told me that she wanted a Georgia drivers’ license and I told her I don’t have a license. I think it’s racism, and perhaps because I didn’t speak English or something they didn’t want to give me the card.” The experience of racism was particularly frustrating for Martina because she felt the need for medical care and felt she was initially denied services because of racist sentiments. “I told them I
needed medical attention. I need the card because without that card I cannot be seen. They do not serve you there in the hospital without a card—to make an appointment you need that card. I think it’s racism.”

Martina continued to describe how she felt racist sentiments even when taking her four-year-old daughter to the doctor. Her daughter is a US citizen and eligible for Medicaid, but the coverage regularly lapses and requires her to re-enroll the daughter. Although she has gone through this processes several times, Martina does not receive notice about her daughter’s re-enrollment process in time. This has resulted in Martina taking her daughter to the dentist and paying over $500 for a cleaning because she was not aware that Medicaid coverage had lapsed. “They don’t send a note or anything, and then I have to pay $500 for a cleaning! And [my daughter] has another appointment the 20th of this month. I went to renew her Medicaid but I’m not sure if she has it or not, and she was born here, she has the right to have Medicaid!” Despite what Martina asserted was her daughter’s right to Medicaid, she explained that she felt racial discrimination when taking her daughter to the pediatric clinic. “Many people do their best to accommodate people and sometimes a doctor will see you as soon as possible, but then sometimes there are people who do not have to wait until their turn and I think that’s racism,” Martina said, passionately. “Because I don’t have papers and I don’t speak English, I think because of that they think I don’t have any rights or the rights of those that have papers...” Further linking discrimination based on language ability, immigration status, and being Latino to not having rights, Martina explained that undocumented immigrants must endure what she believed to be the effects of racism because of their legal status. “[Treating me that way] is racist,” Martina said passionately. “But what they don’t realize is that without Hispanics, work wouldn’t get done. Right now Hispanics work in the fields and did you see how many crops

169
spoiled last year because they deported people? Americans do not work like Hispanics,” Martina continued, “and Hispanics often bear humiliations and sometimes you have a really bad time. But you have to put up with it because you know that you don’t have as many rights as [white non-Latinos] do.” Because of the intense feeling of racism Martina experiences, she explained that she sometimes wishes she were still a farmworker despite the poor labor conditions and pay. “They pay really cheap per bucket, sometimes only $.45 per bucket, and they don’t always give you what you earn, and you don’t get water, and all of us Hispanics are killing ourselves for the boss, and we all get sick because we don’t have enough food and don’t eat like we should…but sometimes I’d rather be working in the fields,” she explained.

“Where do you work now?” I asked.

“Right now I work with this lady at a bookstore. Sometimes it’s better because there’s no sun, but sometimes, a thousand times, I’ve thought I would rather work in the fields.”

“Why?”

“Because the boss is really racist. She is really racist and she humiliates us because we don’t have a driver’s license and she thinks we don't have rights because of who we are. I came here to find better work, but there isn’t as much work now…that’s why they abuse us, because there is no work.” Martina then explained that there are few job opportunities for her and other immigrants so she felt she must take the only jobs she is able to find. I asked if the lack of work in Georgia led immigrants to leave the state, and Martina explained that some immigrants left because of the current immigration laws.

“A lot [of immigrants] left because there is no work, but also because of all the laws that are in this state. All these laws are really hard right now and there have been a lot of laws. And the police and all that, the checkpoints! It’s too much…in other states it’s calmer. Here, we live
in fear when we leave the house.” Corroborating Martina’s assertions, popular media outlets have suggested immigrants have left states or stopped migrating to states for work because of harsh immigration laws (Serrano 2012; The Associated Press 2010). Substantiating these claims is difficult, however, as undocumented immigrants are a hidden population and may not be accurately accounted for by formal population surveillance measures. Nevertheless, there are some data to indicate efforts to force attrition through enforcement does not account for immigrants’ length of time in a particular community (Garcia 2013).

My interview with Martina underscores some of the key impacts of immigration laws and police practices on immigrants in Atlanta. For many undocumented immigrants like Martina, immigration laws and police practices have instilled feelings of fear, led to changing mobility and driving practices, and feeling racial discrimination due to immigration policies and demands for documentation that do not affect the majority of non-Latino, white populations. In this chapter, I provide an overview how immigrant policing impacts behavioral health and leads to feelings of fear and trauma. Borrowing from scholarship on governing immigration through crime, interior policing, and mobility, I demonstrate how fear as governing strategy is a productive violence that restricts undocumented immigrants’ mobility and shapes their health behaviors. As numerous scholars have demonstrated, governing immigrants through crime creates a racialized construction of criminality as Latino immigrants are largely the targets of enforcement efforts (Inda and Dowling 2013), and interior immigration enforcement disrupts social and family life (Capps et al. 2007). These findings point to how “illegality” is shapes undocumented immigrants’ embodied everyday experiences (Willen 2007b), and additional research must pay close attention to immigrants’ experiences and the role of fear, specifically, in governing immigrant populations through interior enforcement (Hacker et al. 2011; Hardy et al.
In focusing on fear as governing strategy and the health-related impacts of immigrant policing, I do not intend to ignore forms of resisting these efforts or disregard what Dowling and Inda (2013: 3) call “migrant counter-conducts” that contest processes of criminalization and exclusion. Resistance to localized enforcement and interior immigration policing are important components to understanding biopolitical aims of immigration laws, as I discuss in Chapter three.

**Governing Through Crime, Local Enforcement, Fear, and Mobility**

The expansion of interior policing follows broader efforts to govern undocumented immigrants through constructing them as criminal others. These efforts are informed by neoliberal notions of deviant and irresponsible “anti-citizens” requiring surveillance and punishment, and post-September 11, 2001 conflations of security and migration that have led to increased border policing and militarization (Chacón 2009; Coutin 2010; De Genova 2002a; Inda 2008; Inda and Dowling 2013; Miller 2002; Rosas 2012). Through programs such as Operation Gatekeeper and Operation Hold the Line, the United States-Mexico border has become an area of significantly increased police activity and surveillance efforts (Inda and Dowling 2013). However, immigrant policing has also further extended into the US interior, as described in previous chapters, extending “the border” into all spaces as part of policing initiative outlined in the Department of Homeland Security’s publication, “Endgame: Office of Detention and Removal Strategic Plan.” “Endgame” promotes interior policing efforts through numerous mechanisms, including raids on locations where undocumented immigrants are suspected to be, and developing partnerships between ICE and local law enforcement agencies to determine immigration status of local arrestees (US Immigration and Customs Enforcement 2003). Borrowing from the ideas promoted in “Endgame,” states like Georgia and Arizona have passed immigration laws to advance state-level enforcement in order to promote “immigrant attrition”
Critiques of state-level legislation to advance local enforcement efforts and promote immigrant attrition question the legal grounds for laws like HB 87 that assume state authority of federal powers, such as immigration enforcement (Chin and Miller 2011), and point to agency and court-related challenges in addressing family separation due to deportation (Thronson 2008). Despite these critiques, interior policing efforts continue, and the promotion of interior policing effectively demonstrates how the border has become deterritorialized, shifting not from the nation’s edge but into interior locations becoming a portable technology of control that asserts immigrants’ criminality (Coleman and Stuesse 2014; Euskirchen et al. 2009; Inda and Dowling 2013). Proponents of interior policing and state-level immigration enforcement, specifically, have directly called for enforcement efforts that push undocumented immigrants into living in a state of “constant fear of detection” in order to promote “self-deportation” (Su 2012). Fear of immigration enforcement certainly occurs in Georgia; following the passage of HB 87, local organizations and places of worship began observing a decline in participation among undocumented members (Trevizo 2011b). In places like Dalton, Georgia, home to the state’s carpet industry, politicians blamed immigrants for a failing economy and immigrants charged that checkpoints and arrests increased, resulting in some undocumented families leaving the area because they feared police (Trevizo 2011b). This chapter focuses on the impacts of fear resulting from local enforcement efforts and pays specific attention to how fear of encountering the increasingly stringent immigration regime may result in changing health behaviors, such as seeking care from specific locations.

Research focusing on health-related impacts of immigration laws has well documented that threats of deportation create emotional distress for immigrants and their families (Miller and
Rasmussen 2010; Silove et al. 2001; Valdez et al. 2013; Ward 2010), which may translate to depression, anxiety, and other mental health concerns (Allen et al. 2013; Hacker et al. 2011; Viruell-Fuentes 2007). Chronic fear resulting from emotional distress related to immigration laws may negatively impact health outcomes (Hacker et al. 2012), and research exploring the relationship between immigration legislation and immigrants’ fear in seeking health services describes how immigrants avoid specific types of care, such as care provided in hospitals and emergency rooms (Maldonado et al. 2013). Furthermore, research on state immigration laws and the impacts of 287(g) and Secure Communities demonstrates how local immigration enforcement asserts a state’s stance of non-obligation for undocumented immigrants’ wellbeing by constructing immigrants as criminals “threaten the safety and well-being of the citizenry” (Alexander and Fernandez 2014: 25). Additionally, scholarship examining the North Carolina context suggests that localized enforcement and state-level immigration laws ensure a docile workforce “necessary for disciplining labor and depressing wages,” (Alexander and Fernandez 2014: 25; Maira 2010), and result in a form of symbolic violence in which undocumented immigrants identify with and internalize their suffering (Alexander and Fernandez 2014).

Findings from this dissertation build upon similar research and contribute to the growing body of literature exploring immigration enforcement, fear, and health-related impacts. As such, it adds to this body of literature by further describing how some immigrants find avenues of care and by detailing how driving and mobility are interrelated components of immigration policies, resulting in fear responses, and seeking health services.

In addition to contributing to literature on fear, health services, and local immigration enforcement, this dissertation and this chapter, specifically, add to literature on immigrants’
mobility through automobiles. Stuesse and Coleman (2014) have described the intense scrutiny of immigrants’ “automobility” through police and legislative action as a way of altering immigrants’ mobility through producing a “climate of terror, in which immigrants live in fear that they may be separated from their families every time they step outside their homes” (2014: 58). Indeed, this research supports how the climate of terror produced through a conglomeration of surveillance fashioned through policing, local laws, and federal initiatives such as Secure Communities and 287(g) restricts undocumented immigrants’ mobility. As Stuesse and Coleman demonstrate, mobility is inseparable from politics and agentive interpretations of contexts shaping mobility. Adding to this discussion, findings presented in this chapter situate attempts to limit undocumented immigrants’ mobility through fear within the context of health and health services.

Moreover, the concept of mobility is important in social science research related to health since mobility can be both a barrier to accessing health services or enabling factor for receiving care. Limited mobility, for example, can hinder access to health services, and among some populations, such as migrant farmworkers, a highly mobile lifestyle is one of many hindrances in receiving health care (Gwyther and Jenkins 1998; Weathers et al. 2003; Wilson et al. 2000). Mobility related to health services is therefore often conceived as a determinant that lies within a spectrum ultimately shaping health; too much mobility hinders health care, and not enough mobility impedes access to services. Rather than solely understanding mobility as a health determinant, however, it is necessary to examine the determinants of mobility itself, which are

\[\text{In this chapter, mobility refers to the ability to freely get from place to place, usually with the use of an automobile. Some health services research conceptualizes mobility as a physical reality, such as being able to move certain limbs, or a social phenomenon related to economic stratification, such as the ability to receive an education, find a well-paying job, and related actions.}\]
linked to broader social phenomena and driven by specific political agendas. For many of the undocumented immigrants I met in Atlanta, mobility was constrained due to fears of encountering police, and these fears stemmed from police practices and policies that could ultimately result in deportation and disrupted family lives. To minimize risk of encountering police, many undocumented immigrants avoided leaving their homes at certain times, altered driving patterns, or avoided certain areas, as Martina mentioned by explaining she and others knew to avoid the road near her apartment complex. Even in times of potential medical need, some immigrants explained they would not leave the house unless it was for work. “Atlanta’s not like Chicago or New York,” one participant explained to me. “You have to take a car to get everywhere… We won’t leave the house unless it’s to go to work, even if someone’s sick and needs medicine—we just won’t risk it because there might be police.” As I describe in the following pages, fear and mobility work closely together to shape undocumented immigrants’ health.

**Experiencing Fear and Trauma: Reactions to Immigration Policing**

“You can’t know what it’s like,” Ariana, a young undocumented woman from Mexico, said to me with tears rolling down her face. “The worst part of all these immigration laws is being afraid all the time—I get into my car and I start shaking. If I see a police car, I start crying because I know they could stop me, I could get arrested and deported, and never see my kids again.” Ariana was born in Mexico but came to the United States with her parents when she was young. Like Ariana, many undocumented immigrants I met in Atlanta described intense feelings of fear related to threats of being stopped by police and potentially deported. For many participants, this was directly related to driving, as one young woman explained: “the worst part of all of this is the constant feeling of fear; I’m afraid to leave my house. I’m afraid of the police
so I just don’t go out. The fear never stops, and it’s so bad that I shake when I drive.”

For some undocumented immigrants I met, fear of driving was directly linked to feelings of personal safety. One participant explained that the threat of encountering police and associated risk of deportation not only made her fearful, but also made her feel unsafe. “I feel like I live in warzone,” she said. “It’s never safe and you have to always be on the lookout. In Mexico, you run the risk of getting kidnapped or killed; here, you run the risk of getting stopped and deported. I’m not safe here, and I’m not safe there—there’s nowhere safe for me.” Echoing other participants’ feelings of fear and trauma, Marisa explained the emotional toll fearing police took on her: “I feel traumatized. All these laws make me feel like I have post-traumatic stress or something. That’s what it feels like—trauma. Every day I leave the house but I’m not sure I’ll return. It’s horrible to live with this constant fear.”

Experiences like Marisa’s point to how trauma exists in a political and social context, and as Fassin and Rechtman explain, “has created a new vocabulary for explaining causes and prejudices” (Fassin and Rechtman 2009: 10). Trauma not only a psychological phenomena, but becomes in many political contexts a resource to “testify to the reality of persecution” or be used to demand a particular right (Fassin and Rechtman 2009: 10). For providers and immigrants I interviewed, trauma was a way to indicate the severity of immigrant policing, particularly the way in which feelings of fear and trauma resulted in related mental health concerns such as depression. As one mental health provider explained of undocumented immigrants facing stress of encountering police, “They’re just so depressed and feel hopeless. They feel like they can’t do the normal things in life they’d like to do.” Several immigrants I spoke to expressed a sense of depression and anxiety, like Marisa, who feared being stopped by police so much that she shook when she drove. Others described ways that people they knew handled policing through
substance use. One man, Miguel, explained that his friends and neighbors who were also undocumented started to drink more than they did in the past. “Ever since all these laws and things, I see them going out, getting drunk, and coming back home late. The drinking has gotten really bad, and it’s because of all these laws.” Miguel explained that immigrant policing limited his and other men’s ability to drive for work, restricting their economic contributions to their households and resulting in frustration that led some men to abuse alcohol. “When men can’t work and can’t provide for their families, it upsets us, and I see a lot people deal with that by drinking.” Other interviewees also explained how immigrant policing resulted in men and women limiting exposure to police by trying to take work in places close to their homes so they could avoid driving, adding that not finding work exacerbated some immigrants’ alcohol use.

Mental health professionals also spoke about connections between immigrant policing, unemployment, and alcoholism. At the Clinic for Education, Treatment and Prevention of Addiction, (CETPA), Atlanta’s primary organization for substance abuse and mental health concerns for Latinos, staff echoed Miguel’s concerns about substance abuse being related to immigrant policing or fears of encountering police. One staff member, who had worked at CETPA since the early 2000s, explained that several patients entering the clinic for substance abuse and addiction treatment expressed some type of mental health concern related to local immigration enforcement. Unlike Miguel’s explanation, however, this staff member did not limit her understanding of substance abuse to men:

We have a lot of clients coming to our clinic because they started getting really anxious and depressed because of these laws and all the checkpoints. We have a lot of clients saying ‘I don’t know what to do, do I have to leave the country? Am I supposed to leave the country? Do I have to go back to another state? I don’t know what to do, I really need help from you guys knowing what to do in this case because my husband has to go out all the time every
day and he has to drive but he doesn’t have a drivers’ license and I don’t know what’s going to happen right now if he has to stop working and I have two or three kids, how are we going to feed them?” I hear this all the time, so we a lot of people coming in because of depression and even more because of anxiety. These were the ones coming in though; a lot of patients stopped coming because of these laws and because they were too afraid to drive.

As many of these accounts of fearing police demonstrate, undocumented immigrants may change their mobility as a result of immigration laws and fearing encounters with local police. These concerns manifest in specific health concerns, such as trauma and chronic fear, and also shape specific health behaviors, such as seeking health services.

**Finding New Avenues of Care**

For many immigrants I met, fears of encountering police while driving often translated to limiting time in the car, much like Martina explained she no longer drives to get out of the house or do anything other than what is necessary. The risk of encountering police while driving was only acceptable when driving to work or running necessary errands such as going to a grocery store. Limiting potential exposure to police therefore meant some immigrants avoided driving even if there was a situational need like feeling sick. As Marisa, a mother of three explained, “it’s just not safe to drive, not even if I’m sick. What would I do if they stopped me? Who would take care of my children?” When necessary, however, some participants discussed going to clinics they considered “safe.” These clinics were typically small facilities that have proliferated along Buford Highway and in other locations with many Latino immigrant residents, and usually feature signs in Spanish with names such as “Clínica de la Salud Hispana” or “Clínica Latina” and advertise to Latino patients. Numerous health providers I spoke with expressed concerns over the legitimacy of these clinics, suggesting that patients overpaid for care, were not treated by “real” or licensed physicians, and overpaid for services.
“Sure they won’t ask you for a social security number,” one provider at an Atlanta hospital said, “but will they give you the right treatment?” Providers’ claims about Latino clinics are difficult to verify without insider knowledge of how all the Latino clinics operate, but recent news stories have shed light on fraudulent activity occurring in some now-defunct Latino clinics, including one that repeatedly came up in interviews and was highly visible from advertisements: Clinica de la Mama. The clinic operated numerous locations in the Atlanta area, one of which was in Plaza Fiesta, the shopping mall where several of GLAHR’s popular education events took place. I had attempted to interview staff at Clinica de la Mama, but by the time my research was approved by the USF Institutional Review Board (IRB), the clinic had abruptly and mysteriously shut down. I much later discovered that the clinic was embroiled in a serious lawsuit for committing Medicaid fraud, and ultimately leadership of the company operating the clinic admitted to channeling undocumented pregnant women to specific hospitals for a kickback fee (McDonald 2014; The United States Department of Justice 2014; Weaver 2014). The scheme allowed hospitals to increase revenue from Georgia’s Medicaid program as clinic staff would direct undocumented pregnant women to delivery babies at specific hospitals and discourage them from delivering at other locations, suggesting Medicaid may not pay for the deliveries (McDonald 2014). The fraudulent business practices do not necessarily speak to the quality of care provided to patients, but nevertheless suggest Clinica de la Mama’s interests were not entirely focused on patients.

Corroborating recent news stories and providers’ suspicions regarding the trustworthiness and quality of care at Latino clinics are explanations from immigrants like Sandra, a young undocumented woman I met through GLAHR. Sandra explained that she prefers to visit a “Hispanic clinic,” as she called it, when she is sick. “I go to Clínica de las Americas if I’m
sick…you may pay more and they may not give you the right medicine, but I just feel more comfortable there. I know it’s safe.” For Sandra, the feeling of safety was more important than quality of care or cost of care, mirroring comments from several other participants about wanting to find care in a safe location. As Sandra’s mother explained in a separate interview, “we Hispanics know that there are places where you can go and they won’t ask you for a social security number…they’ll attend to you without asking you if you have a social security number or not—they just see you and you pay. Those are the places we know are safe.”

In addition to seeking health services at Latino clinics, some immigrants I interviewed reported finding other avenues of care because of checkpoints and fears of encountering police. New avenues of care included self-medicating, seeking traditional healers, and receiving care from informal providers operating treatment facilities in their homes. As one participant explained to me, “If we’re sick we just go to the farmacia at Centro Hispanico. They get shipments in from Mexico so you go and tell the person there what you have and they give you something.” Similarly, another participant explained that rather than going to a health provider, their first choice in seeking treatment for a specific health condition was a farmacia. “For us, we know from our countries where we come from what’s good and what you can take care of without visiting a doctor. You don’t need to go to a doctor for everything, so you go there to Centro Hispanico and you ask about something, and you buy it, and they give you what you need. You don’t have to go to a doctor.” For situations requiring a medical professional however, some interviewees reported going to traditional healers, such as hueseros, a type of folk healer. As Sandra explained, “Sometimes I go to Doña Maria, the huesera. She gives me this stuff to drink and it tastes nasty but it makes me feel better.”

---

34 The name “Centro Hispanico” is a pseudonym to protect the location of the actual farmacia.
In addition to visiting traditional healers such as hueseros, some participants also reported visiting providers operating clinics in their garages or on their balconies. One woman who worked for an immigrant health organization explained this was common practice, particularly for seeking oral health services.

Instead of going to a dentist, like a normal one that we would all go to, they go to somebody with a chair at home with their personal stuff but operating illegally and doing everything that they can do to a mouth. I’ve done it myself. Like in Colombia or Mexico, for example, they were dentists and then they come here and they can’t do it, so they have to go illegal, not that they have to, but they do, some people do. Since it is, for example, $25 for something that would cost $100, people go there. I have done it myself. I had a tooth fixed. He had a chair; there was a drill and everything. It is just like being in an office except it is in their dining room or on their porch. Mine was in an enclosed porch in a condo. There’s one really close by in a trailer park, so if you ever need something I can refer you! It’s in a trailer park and some people also go to people who get involved in witchcraft, or with a curandero. We have one next door…I’m so against that. It’s kind of like witchcraft, and it’s like the remedy is worse than what hurts you!

Several undocumented immigrants expressed that seeking services at a curandero, from a Latino clinic, or from informal providers was not only more economical, but better than seeking care from other locations because it was safe. “We know they’re safer than a hospital. If we go to a hospital they might ask for a social security number or there may be police there. At least with [other forms of care] we know it’s safe, even if you don’t get cured,” Sanda explained.

When I asked Sandra how she and others decided when they would go to a hospital, she noted that visiting a hospital was not typically a viable option. “I have to be dying if I’m going to go to the hospital, like dying, you know? It’s just not worth the risk to go to a doctor if you feel sick.” Sandra then explained that hospitals were last resorts; farmacias and healers were the first form of treatment, followed by smaller, Latino clinics. Sandra, however, had been to Grady
Hospital when she fell ill and developed a fever that left her unconscious.

“I don’t remember what happened—I just passed out and I guess my mom called an ambulance,” Sandra explained.

“I was scared, but they took me Grady and I got a Grady Card and everything, and I’m still making payments on when I had to go to the hospital, but it was okay.”

Like Sandra, other interviewees shared similar sentiments about self-medicating before seeking medical attention at hospitals, and several participants described Grady as a place where undocumented immigrants can go when they are sick.

When discussing Latino clinics and the use of informal providers with health providers working at major Atlanta-area hospitals and leaders of health organizations, some expressed concerns over what one provider called “black market medicine.” In describing the Latino clinics that line Buford highway and nearby streets, several providers questioned the quality of care received at the clinics but recognized that patients felt safer going the smaller clinics. As one provider, Dr. Samuel, noted, these clinics are typically cash only facilities where Latino patients may feel safer because they do not expect a potential threat for deportation. “They’re not free clinics but they’re clinics where they can be seen and feel safe to go to, but they cost them out-of-pocket.” Dr. Samuel questioned the quality of these clinics, however. “I don’t know the people staffing those and I don’t know the quality of the people staffing those, but I’ve seen some badness coming out of there, like sick people who then come to me and I say ‘they told you what?!’ I don’t want to disparage them because I just don’t know. They're like little urgent cares.”

Like Dr. Samuel, another provider, Dr. Hernandez, an OB/GYN with a large Latina patient population, expressed concerns with small clinics targeting Latinos because she was unsure that they provided adequate care. Dr. Hernandez is a native Spanish speaker who has
lived in Atlanta for nearly twenty years operating her own OB/GYN practice associated with one of Atlanta’s larger hospitals. Her clinic is located in an area accessible to numerous Latino patients, and she occasionally participates in non-profit Latino health organizations.

You have the little clinics that will do the $25 Pap smear, but the problem is that a lot of these clinics do not have specialty doctors, so I see a lot of patients that will come in and bring me stuff that’s been given to them and they end up paying more because they don’t get properly treated and they keep going and they do this and that and then eventually somebody says ‘you need to go to Dr. Hernandez.’ So they have wasted all this money on stuff that wasn’t going to make them better to begin with…So they will go to these clinics, and I wish they would regulate that more. There’s one clinic that’s really, really famous and the guy that runs it is not even a doctor—Clinica de las Americas en Georgia. If they go there it’s because they’re afraid to apply for anything [like Medicaid] but they don’t understand that the clinic then says ‘okay the fee is $500,’ but then the office takes it upon themselves to apply for emergency Medicaid and they’ll get the emergency Medicaid. So it’s not like the clinic is doing it for less money, they do apply for emergency Medicaid and they make patients sign papers and all that stuff. They do all that and they get terrible care.

When I asked Dr. Hernandez to elaborate on her concerns with Latino clinics offering care that undocumented patients considered safer than care in other locations, she questioned some providers’ training and treatment practices. “Sometimes I see patients that are being treated for early cervical cancer by these clinics and they don’t even do LEEP36 on them,” Dr. Hernandez said, shaking her head as she spoke. “They don’t do the proper staging on them, so then I get them in and of course they found out that they have this, and they discover it’s a little bit more involved and at that point it’s like ‘oh go here’ and they send them to me.” Dr. Hernandez further questioned the providers’ training, wondering if they had proper education or were doing

35 This name is a pseudonym to protect the location of the actual clinic.
36 LEEP, or loop electrosurgical excision procedure, is one of the most common ways of treating cervical dysplasia.
procedures just to make a profit. “[Just] because the person that technically does these procedures is not an OB/GYN, they’re just people who go to one course, just like if I were to go to one course and then start. By the same token, there are these people who go to a one-week course on liposuction and then they’re doing liposuction because they want to make money.”

Figure 12: An example of a Latino clinic no longer in operation.

In addition to the expressed concerns over care provided at small Latino clinics, Dr. Hernandez expressed frustration with pharmacies providing medication to Latino patients and clinics targeting Latinos, particularly prenatal clinics:

I know we have pharmacies that cater to the Latino community and I know that they can get so-called ‘prescription drugs’ without a prescription…So I think that is scary and I can’t believe that nobody is doing anything about that, nobody. So that is one of my big issues. I think one of the other issues that kind of bothers me is
that there are clinics that are geared for Hispanics and they probably have Hispanic doctors, and I can’t really speak to the quality of care that they give but I do know that to me they don’t do what they are supposed to do.

As an example of some clinics not doing what Dr. Hernandez felt was appropriate, she described prenatal care visits. “When a woman goes in for prenatal care in our system, that postpartum visit is part of her prenatal care because you are considered to be in a pregnant state until you’re six weeks postpartum,” she explained, noting the importance of a postpartum visit. “That postpartum visit is crucial, and one of the things that I found is that a lot of women came here for just that postpartum visit, saying ‘well my doctor said just come here.’ And I’m like ‘No!’” Dr. Hernandez found it particularly outraging for providers to send her patients that she had no history of working with. “[I have to tell them] ‘we didn’t see you for your pregnancy, we don’t have any notes about your pregnancy, I don’t know whether you had any issues with your pregnancy or not, and for me to just do your postpartum care blindly?’” Dr. Hernandez continued by noting that she felt this was a form of extorting patients for money:

It used to infuriate me because if you are going to charge them money to take care of their pregnancy that [postpartum] visit should be included even if you have to charge a fee of $100 or $200, but when they call to get their postpartum visit and you just say ‘go to the health department?’ I think in some ways that there’s just some substandard care that they get…Who is guiding them, who is helping them, who is making that decision, who is deciding what is best for them? And then to be turned away for basic care that should be part of what they do! It’s upsetting!

Continuing to express concerns over pregnant patients’ wellbeing, Dr. Hernandez noted that some clinics may not have physicians, including the well-known clinic on Buford Highway, Clínica de la Mama. Pointing to examples of what she thought was poor care and describing care provided from staff who were not licensed medical professionals, Dr. Hernandez suggested that
patients at places like *Clínica de la Mama* do not “get real care.” Sharing Dr. Hernandez’s sentiments, regulating informal clinics was a particular source of irritation for a local health department leader, whose department sees a large number of Latino patients.

I’ve had Hispanic women come in and their blood pressure is through the roof and they have a history of high blood pressure and they say ‘well I was on blood pressure medication until last year,’ and I will ask ‘why did you stop?’ ‘Well my doctor said I was cured.’ And I tell them, ‘you are cured because you’re on the medication—did you ever go back after you stopped?’ ‘No, no, he just said I didn’t have to take it anymore,’ so I even wonder whether or not some of these people are even healthcare providers or if they just printed up something and put it on the wall because who is regulating them, who is looking at them? And I really don’t know, I don’t know the answer to that but just the stories that I’ve heard from the clients make me think ‘are you kidding me?’ I find [the care they have gotten] very disturbing.

In considering why some of the smaller clinics are not regulated, Dr. Hernandez explained that accepting health insurance requires a type of insurance audit and regulation system that the smaller clinics avoid. “Here we take insurance,” she explained. “A lot of times insurances will come audit, and when they come visit if you don’t [meet specific requirements] they drop you from insurances. But over there [at the Latino clinics], typically it’s all cash, so nobody goes and really checks them.” Like other providers, Dr. Hernandez suggested that the smaller Latino clinics may exploit their patients in addition to providing substandard care.

They’ll go into this place for one problem and they’ll say ‘oh it could be this or this and you have to have this test.’ So they’ll go for the cheap Pap smear but then they get a lot of ‘guess what? You have you have to take this medicine,’ which only they sell. A lot of times patients will bring the bags of medicines, and they

---

37 The Georgia Department of Community Health regulates healthcare facilities and does background checks on employees and owners. Dr. Hernandez may be suggesting that the Department of Community Health does not follow up on initial checks, or that the clinics are operating unlawfully.
didn’t need any of it. And I’ll ask ‘well how much did you pay for that one?’ That was $34 and this one was cien ($100).’ So there in the bags is the [cost of the] visit where they could’ve come to me and gotten the right treatment. There’s a lot of providers taking advantage because you know [the patients] work hard and have only cash…and I guess we all take advantage of them because they pay into Social Security otherwise it would be broke…

Although some providers like Dr. Hernandez explicitly felt that Latino clinics took advantage of their patients, many of the GLAH Riadores felt the Latino clinics were an appropriate option for care, including Clínica de la Mama.

“You should talk to Clínica de la Mama,” one GLAH Riador encouraged me.

“They help a lot of people.”

When I attempted to visit Clínica de la Mama after my IRB had been approved, the Buford Highway location in Plaza Fiesta had closed and been replaced by a Children’s Healthcare of Atlanta clinic, a pediatric care organization with multiple locations in the state. My request for interviews with leaders of the new children’s clinic was denied, as were my attempts to meet with leaders of other local small clinics. I later discovered the scandal involving Clínica de la Mama, and another clinic owned by its corporate parent, Clinica del Bebé.

In addition to shaping where some immigrants seek services, immigration laws shape immigrants’ mobility in an increasingly intimate and personal way by altering preventive health behaviors. With at least one person I spoke to, fear of encountering police became an internalized threat.

**Changing Health Behaviors**

While fear of encountering police in everyday spaces resulted in changing driving behaviors and where some immigrants found health care, fear also shaped other activities. This was especially true for Rosa, a middle-aged woman with arthritis.
“I have arthritis and I’m trying to stay healthy,” she explained. “My doctor recommended I go for walks, so I try to go for walks every day.” Rosa lives in Cobb County and her husband provides the main source of income for their family. I met Rosa through a GLAHRIador and started interacting with her through text messages. One day I received a text message from Rosa explaining that a police car was following her while she was walking. When she and I met, Rosa told me that walking is the only type exercise she can get because high-impact activities are painful and may harm her joints. Despite recognizing the need to exercise and knowing the only type of exercise she can engage in is walking, Rosa explained that police practices may stop her from her preventive health behavior. “I walk because my doctor recommended it since I’m a little overweight and have arthritis…if the police start following me around all the time, I won’t be able to go out anymore. How will I exercise?”

Rosa’s situation is complicated by her husband Eduardo’s recent arrest. When Eduardo was arrested for driving without a license his immigration status was discovered, and he now faces a deportation charge.

“We’re here for Rosa’s treatment,” Eduardo explained. “Here she can get the treatment she needs.” Rosa regularly receives cortisone injections to relieve the symptoms and inflammation of her arthritis, but she and Eduardo claimed they would not be able to receive this type of care in the part of Mexico where they are from. If Eduardo is deported, Rosa is unsure how she will be able to afford the cortisone shots.

Contemplating no longer adhering to a recommended exercise regimen is not the only type of treatment reconfiguration immigrants contemplate because of increasingly stringent immigration laws and police practices. Several immigrants and providers I spoke with also explained that they only seek treatment during specific times even though services are available.
Avoiding police therefore translates to not just avoiding specific health service locations that may not be considered safe, but also avoiding seeking treatment or purchasing treatments during specific times of day, including the evening. As one woman said to me about driving during the evening, “driving at night is too risky. We don’t leave the house after 10:00pm because there are too many police around. It doesn’t matter if you’re sick, if you need medicine—nothing. It’s too risky to leave the house.” A CETPA provider expanded on this idea and noted that offering group mental health services in the evening became increasingly difficult following the increased number of checkpoints and roadblocks in the area because undocumented clients fear encountering police on the way to their appointments.

Clients will tell me “oh well I know I need it but I can’t come every week or I can’t come to the group because the group is at nighttime and I’m scared to drive in the nighttime because that’s when I can get stopped and arrested and I’m really, really scared.” So people will not come in for their full services because of fear. They would rather go in the daytime when they feel safer to drive or to come, but definitely not in the nighttime.

Safe spaces for treatment were therefore only safe during certain times, as this provider explained. If patients do seek services but attempt not to drive, the costs of seeking care become higher, as one provider explained.

A lot of our patients won’t drive. They won’t drive because they are scared to get pulled over because they hear ‘oh we pulled you over because that light was out’ and they feel like police are making something up to pull them over so people don’t drive. In one family one woman walks to church every day and then she walks to three different schools to pick up her kids and then she walks home because she won’t drive. But that affects them coming here for sure, because now they have to pay a taxi or ask a friend and that’s on top of their visit, so it’s even more expensive to get medical care…we try to offer low cost services but then they have to pay for a taxi!

The mental health impacts of fear and constrained mobility even when services are available has
potential long-term impacts on Latino communities. As one CETPA employee noted, frequent police checkpoints and deportations led to anxiety and generally negative feelings about police. “There’s a lot of hatred,” she explained. “You hear people talking so bad about the police and law enforcement, there is not a good relationship even though some police have tried. At least a couple of police have expressed that they would like to have more community ties specifically with the Latino population but I don’t see that happening.” Similarly, another provider noted that among her undocumented patients police were considered harmful and a threat: “They don’t see the police anymore as somebody who is going to protect them, but somebody who is going to harm them or punish them.” The negative relationship between police and local Latino communities was a point of organization for some groups, such as the Cobb United for Change Coalition (CUCC), but numerous providers and immigrants explained that negative relationships between Latinos and local police persisted, which in some scenarios exacerbated health-related problems, such as intimate partner and family violence, as I discuss in the following chapter.

Discussion

Exploring health-related impacts of immigrant policing and immigration laws on undocumented immigrants reveals themes of fear, changing mobility, and altering health behaviors. These impacts reveal a type of fear-based governance relying on policing regimes to execute a specific form of hidden violence. Interior immigration enforcement changes undocumented immigrants’ mobility as part of a fear-based technology of governance made possible through criminalizing the population by employing, in part, neoliberal notions of responsibility. Responses to governing immigrant through fear have included the opening of Latino clinics, which serve as a form of parallel medical care, but these spaces may reinforce racialized differences as they are associated with one population and develop out of a racialized
enforcement and criminalization context. I further discuss how some undocumented immigrants, like Martina, understand enforcement activities through the lens of race and describe how racism is a portable form of oppression that can be carried into numerous spaces, including medical settings. Maintaining focus on the role of law enforcement in perpetuating fear-based governance, I lastly discuss “pathogenic policing,” or the way law enforcement impact marginalized populations’ health.

**Changing Mobility**

The most immediate impact of immigration enforcement on undocumented immigrants is constrained mobility, which, as I have shown, ultimately impacts health care access. Since mobility is essential to seeking and receiving health services, constrained mobility reduces the types of care immigrants can access, and some immigrants may be less likely to seek services at specific times or in places far from their homes. Stuesse and Coleman (Stuesse and Coleman 2014) have discussed the ways immigrants in Atlanta respond to a regime of police surveillance focusing on mobility through “altermobility,” finding new transportation and mobility strategies, and in some cases have relocated in order to ease mobility. As they note, in response to increased checkpoints and police presence, mobility strategies developed to alert immigrants of potential checkpoints, such as *PaseLaVoz*, a text message subscription service that notifies subscribers of nearby reported checkpoints. Furthermore, local businesses suffering from a decline in Latino patrons began driving customers to and from stores so their businesses would not suffer from the increased police activity. Adding to these types of mobility-focused resistance to enforcement, I describe changes in health-related mobility.
As findings from this chapter demonstrate, altermobility extends into the health realm not just by shaping when immigrants drive or which routes they chose to take, but also by forcing risk calculations about locations and service providers that are considered safe and minimal risk for encountering police. Altermobility is thus not only applicable to geographic space and subscription-based social networks like “Pase la Voz,” but also health service spaces where immigrants are less likely to feel the potential scrutiny of immigration enforcement officials. Examining health-related altermobility, however, requires assessing the techniques underlying changing mobility, such as fear.

**Fear-Based Governance**

Like other recent research on immigration enforcement and health, this dissertation focuses on legislative attempts to encourage immigrant attrition in order to understand the impacts of immigration laws and concomitant feelings of fear on health and seeking health
services. The situation I describe in Atlanta underscores how some immigration enforcement regimes not only extend into local spaces, but also serve as a form of self-governance that shapes undocumented immigrants’ willingness to seek specific types of health services.

As I argue in Chapter Three, aggressive and local enforcement regimes occurring against a backdrop of racialized criminality constructs undocumented immigrants as ideal neoliberal citizens who reduce their use of specific services but continue to engage in labor system without making demands for resources. This chapter demonstrates the way fear is a central component to the process of creating the ideal neoliberal citizen who makes no demands on the state but provides cheap labor. Undocumented immigrants’ and health providers’ experiences reveal how federal and state immigration laws interact with local police practices to produce a system of regulation and authority (Rose 1999) that hinges on notions of fear. As legal scholarship suggests, fear is intended in state-level immigration enforcement (Su 2012), and since anthropological work on the impacts of immigration enforcement and health has identified fear as key component determining reduced use of services (Alexander and Fernandez 2014), the promotion of fear itself demands detailed attention.

Scholars exploring local level enforcement efforts have noted the role of fear in state-level immigration laws and police practices in places like Arizona (Sáenz et al. 2013) but have not provided sustained attention to the role fear plays as a governing strategy. When put into analytical focus, understanding fear as technology of governance to fashion a type of hyper-exploited neoliberal citizen allows for understanding how fear becomes a productive form of violence that operates to advance biopolitical aims. Many undocumented immigrants in Atlanta fear driving and describe a sense of trauma associated with potentially encountering police, which ultimately limits their willingness to seek health services or engage in preventive health
behaviors like walking for exercise in public spaces. As a result of routinized fear, immigrants I met changed health behaviors, where they sought care, and driving routines. These changes in response to fear ultimately create separate types of space for undocumented immigrants that can be considered safe, such as Latino clinics. Spaces such as Latino clinics fill voids that become created through enforcement, but they reinforce racial division underpinning immigrant enforcement efforts since the spaces themselves become racialized as they are used only by those that need to find places safe for care. This effectively reinforces components of race-war logics that are an integral component of biopolitical control.

As fear through policing activity produces a specific biopolitical aim but also manifests in what some immigrants describe as trauma and identifiable physiological effects, like crying and shaking while driving. Examining the trauma produced from constant fear can be understood as a type of violence inflicted upon those targeted by policing efforts. Much like Linda Green describes fear as “chronic condition,” embedded in the social fabric among Mayan women in Guatemala (Green 1994), the situation I describe in Atlanta points to a type of fear and insecurity that persists in individuals’ lives and becomes routine. Although Green focuses on overt violence, the situation in Atlanta is a more subtle way of producing a fear response, masked through the seemingly neutral and innocuous but formal arena of policy and law. Fear-based governance resulting from immigration policies is therefore a more alarming form of hidden violence that operates more secretly than overt violence while condoned through the guise of national security.

Beyond understanding hidden operations of fear-based governance, immigration enforcement in Atlanta further reveals the workings of biopower and governmental power generally. The use of fear in Georgia through immigration legislation promotes a specific governmental objective made possible by working on bodies. It is through the fear processes that
undocumented immigrants in Georgia become more malleable to the architects of enforcement processes as their specific behaviors may change, such as limiting mobility and changing health behaviors. Fear, therefore, is a route of biopower—a mechanism with which to control populations. Although fear can serve biopolitical objectives, not all populations are governed through fear, suggesting governing through fear can only work in tandem with social vulnerabilities, such as being vulnerable to deportation (deportability). Governing through fear therefore points to how some governmental practices use exploitation for control, and in the case of undocumented immigrants, their exploitation is made possible by the government-created vulnerabilities fashioned through the status of being undocumented. Accordingly, the situation in Atlanta provides examples of how governing can occur through exploiting vulnerabilities that were initially created through other processes of governing, such as undocumented status. Undocumented immigrants could not as easily be governed through fear if they were not first given the status of being undocumented by the governmental authority devising methods of control. In other words, controlling undocumented immigrants through fear is partly possible because of a layered form of vulnerability that includes undocumented status. This reveals an important aspect about governing processes: that governing populations may require more than one technique of governing, or a layered type of governance, and the layers may help mask unequal types of control and associated outcomes, such as disparate access to health services.

In considering how immigration laws act as a form of fear-based governance, Green’s work (1994; 1999) further suggests how fear can persist even in the absence of the conditions creating fear. Green argues that in the absence of the state-sponsored violence that created widespread fear in Guatemala, fear persisted as a form of trauma, suggesting troubling impacts for undocumented immigrants in Atlanta living in fear. Green’s work suggests that fear resulting
from a traumatic event, such as policing efforts, as some informants described them may linger or be permanent. Even if resistance efforts translate to policy change, the effects of fear may persist and may continue to impact immigrant populations, underscoring how governing processes can outlive a specific policy or law. In this respect, fear is a productive type of governance in that it produces specific internalized systems of self-regulation and can outlive the system that created it. Resistance efforts may therefore require not only challenges to immigration laws and police practices, but may also need to engage in efforts to reverse the consequences of persistent feelings of fear and trauma. Resistance efforts may therefore ultimately requiring using experiences of trauma as a strategic aim in asserting immigrants’ rights.

As Fassin and Rechtman demonstrate in highlighting the social and political contexts that shape trauma, experiences of trauma can have utility and result in social mobilization to demand rights and resources (Fassin and Rechtman 2009: 10). In the case of undocumented Latinos and trauma related to immigrant policing, experiences of trauma can provide a framework for a shared experience of violence around which to organize like other shared notions of suffering (Fassin and Rectman 2009:16). Unlike other forms of trauma and suffering, however, the insidious form of violence resulting from immigrant policing is not marked on immigrants’ bodies, but may result in altered subjectivities and a persistent memory of trauma that shapes relationships. Just as Veena Das (2007) demonstrates with the violence and national trauma of Partition in India, violence directly related to political change can transform family and community relationships, creating forms of tension and resentment. For undocumented Latino immigrants and their families, changing relationships may manifest in distrusting police, and although some research suggests Latinos hold lower perceptions of police than Caucasians
some findings suggest that Latino perceptions of police depend on variety of factors, and that in some settings Latino immigrants have better perceptions of police than non-immigrant populations (Correia 2010). In Atlanta, the fear and trauma produced through immigrant policing may contribute to a lasting negative perception of local law enforcement.

“Black Market Medicine:” Parallel Medical Care in Atlanta

In addition to perpetuating a type of fear-based governance that results in feelings of trauma, immigrant policing further impacts undocumented immigrants’ health by creating an increased demand for health services considered safe or free from risk of encountering a deportation threat. As data from this chapter highlight, the creation of an informal care system to treat undocumented immigrants was often associated with receiving substandard care, financial exploitation, and a general sense of clandestineness, leading one provider to call it “black market medicine.” Despite these concerns, however, Latino clinics and unregulated care through pharmacies and providers operating out of their homes continues to be a viable source of receiving health services in order to avoiding encountering police.

The development of informal care systems in Atlanta follows other models of multi-tiered health care in which discrepancies in types and quality of care for marginalized populations excluded from mainstream health services due to income, race, education level or other forms of marginality (Frank et al. 1995; Mor et al. 2004; Wyss et al. 1996). In places with universal health coverage, tiered health care exists to provide a parallel medical service to government funded care. Two-tiered medical care in universal health systems also raises concerns over inequality (Naylor 1999), suggesting that even in cases of universal care the existence of a parallel medical care system indicates medical inequalities. In Atlanta, the
existence of a parallel system of care suggests health inequalities exist not necessarily because of access, but because of fear of utilizing one tier of medical services offered in large health care facilities, such as hospitals. Undocumented immigrants may be eligible for subsidized care at Grady hospital as Fulton and Dekalb County residents, but may avoid care and seek services at Latino clinics because they fear encountering police. In this scenario, a parallel medical system has developed not because of lack of access, but rather because of a need for a health services option that is perceived as safe and less likely to be associated with risks of encountering police.

The development of parallel or tiered medical care in response to fear of encountering police is a particularly important contribution to immigrant health literature. Although immigrant health literature documents fear of having documentation status discovered as a factor in seeking health services (Asch et al. 1998; Berk et al. 2001; Heyman et al. 2009a), existing literature does not explicitly examine the notion of personal safety (not the medical and hygienic notion of safety) and its relation to where undocumented immigrants seek health services. Although literature on where undocumented immigrants may examine how fear of having their immigration status discovered plays a role in whether immigrant seek services, findings from this dissertation suggest a more nuanced way of making safety calculations that impact how undocumented immigrants seek health services. Furthermore, paying specific attention to notions of health sites as “safe” allows for understanding how quality and type of care is not always the most valued aspect of receiving care for some undocumented immigrants, but rather minimizing risk of encountering a potential agent of a broadly dispersed deportation regime.

While seeking care from Latino clinics that are considered “safe” for undocumented immigrants can be considered a resistance effort to immigrant policing, I hesitate to refer to this type of care as resistance because of insufficient evidence indicating that the quality of care is
acceptable. To the contrary, the care received is often considered inferior, even by undocumented immigrants such as Sandra, who agreed that the care was likely not the best, but suggested the assurance of safety outweighed the importance of good medical care. Accordingly, the existence of Latino clinics may be a form of medical exploitation made possible through fear-based governance and survival strategy in a climate of increased policing rather than a form of resisting biomedical hegemony or local immigration enforcement. These findings are limited, however, as I was unable to conduct interviews with providers in Latino clinics. Clinica de la Mama, for example, was a clinic Inés and several GLAHRIadores recommend I visit to do interviews, and the clinic abruptly went out of business, likely because of its pending lawsuits for fraud. Providers from other Latino clinics were also hard to reach as a front desk gatekeeper would ask me to leave a card they would pass on for permission to do an interview, or take my name and leave messages for administrators in charge. Accordingly, findings regarding informal care networks are limited by having not been able to interview informal care providers.

Feeling Racial Discrimination in the Clinic

Although Latino clinics may exploit Latino populations, they also serve as a potential space for not encountering the racial discrimination Martina felt she experienced in some settings. When explaining her challenges in Atlanta, Martina spoke openly about feeling racism and discrimination, especially when claiming “that’s why they abuse, because there’s no work.” Martina’s racially-infused abuse was so severe she considered returning to migrant farmwork rather than continue to experience the racial discrimination she felt in her workplace. Instead of feeling racism confined to the workplace, however, Martina also felt racial discrimination in medical settings, raising questions about how medical treatment may be differentially provided based on race. In considering Martina’s experience but having never personally observed racial
discrimination in an Atlanta clinic, the notion of triage is especially useful to consider the potential for medical racism as well as misunderstanding clinical systems of ordering that become additional examples of latent racism.

From a medical perspective, triage is the way of ordering treatment based on severity, involving the necessary sorting of patients and allocation of resources. In expanding this term to include how medical resources are allocated based on medical needs and social conditions, Vinh-Kim Nguyen demonstrates that the triage can balance numerous agendas (Nguyen 2008; Nguyen 2010). When interpreted by someone like Martina who acutely feels racism in her daily life and senses the racist sentiments with which policies and police practices directly impacted her and her community, triage becomes a phenomenon intimately linked to oppression and racialized otherness. Although triage as a system of ordering may exemplify inequalities for treatment that are accepted, such as having a severe illness requiring immediate attention, the experience of ordered care in a medical setting can become interpretations of an overly hostile environment fixated on race, such as intense forms of immigrant policing. Experiencing racial discrimination in medical settings therefore demonstrates how racism, like enforcement, can become a portable and antagonistic sentiment intimately felt by people like Martina.

Sentiments of racism are felt as governing immigrants continues to occur through crime, and as governing through crime produces and reinforces racialized notions of criminality. As Doty (2013) discusses in describing border deaths and enforcement practices, understanding immigration enforcement and criminality through biopower allows for considering examining how race becomes an important consideration in immigration politics. Doty writes that “Nation, citizen, and race have been historically intertwined in complex ways that are virtually impossible to unravel,” and while this indeed true, interior policing efforts targeting Latino immigrants that
produce them as a type of criminal other effectively demonstrate a type of racial politics that determines who are desired citizens and who are not. Interpretations of being an undesired citizen can thus extend into multiple spaces and extend into multiple forms of citizenship, such as medical or patient citizenship.

Although I have no way of determining if and to what extent racial discrimination occurs in certain medical settings from the findings in this research, Martina’s explanation of racial discrimination in clinical settings nevertheless underscores how race is a portable technology of intimately felt oppression and is also used in assertions against racial discrimination. For example, in describing how she felt racially discriminated against Martina employed racial rhetoric to assert the value and importance of “Hispanic populations,” claiming that without their labor, the US economy would not be as successful. Although this hints at transnational labor exploitation bound together in economic and social inequalities, Martina only explained her feelings of racial discrimination and responded with racial rhetoric, highlighting how race can serve to obfuscate complex social systems that sustain inequality. Martina’s experiences reflect what other researchers have identified as a process by which immigrants internalize social hierarchies surrounding medical care and perceive discrimination due to undocumented status as a barrier to non-emergency health services (Heyman et al. 2009c; Horton 2014).

Pathogenic Policing

Lastly, examples of how immigration laws and police activities impact immigrants’ health contribute to the growing body of literature of health-related consequences of policing marginalized population. In their work among San Francisco’s homeless, for example, Bourgois and Schonberg (2009) describe police activities that can result in negative health outcomes for homeless intravenous drug users, which they describe as “pathogenic law enforcement” (2009:
Moreover, Bourgois and Schonberg suggest a relationship between criminalization, subjectivity formation, and deleterious health outcomes, arguing that criminalizing drug and syringe use and focusing law enforcement efforts on public urination, intoxication, and sleeping exacerbate harmful injection practices and further push drug users into more hidden spaces that reinforce their criminal subjectivities (Bourgois and Schonberg 2009: 113). More recently, “pathogenic law enforcement” has been applied to undocumented immigrants susceptible to “interior policing” (Capps et al. 2007; Dowling and Inda 2013) to demonstrate exacerbated health concerns resulting from avoiding care due to increasing police activity (Alexander and Fernandez 2014). “Pathogenic law enforcement,” or pathogenic policing, is a useful analytic to examine the relationship between law enforcement, marginalized communities, and health outcomes. Departing from previous work on pathogenic policing, I further assert that this idea must be contextualized within neoliberal ideals and efforts to constructing criminality.

Criminalization processes that target homeless drug users and undocumented immigrants are constructed around neoliberal logic that imposes a notion of responsibility for citizens to provide their own services. Deviant, irresponsible citizens unable to provide for themselves, like the homeless, or citizens who are judged as misusers of welfare benefits, like undocumented immigrants, are deemed worthy of punishment because they “[lie] outside the nexus of responsible activity” (Dowling and Inda 2013: 4). In failing to comport with neoliberal logics of self-sustaining responsibility, marginalized populations like the homeless or undocumented immigrants face punishment made possible through criminalization of particular behaviors. Several scholars have pointed to how notions of deviance and noncompliance with neoliberal

---

38 I prefer “pathogenic policing” because it emphasizes the nature of policing behaviors and draws into question the politics of policing, whereas “law enforcement” seems more benign and acceptable since it suggests simply complying with the law.
aims have served to uphold white power structures and suggest non-white populations are inferior (Neubeck and Cazenave 2001: 4; Roberts 2011). Understanding pathogenic policing through notions of criminalization that reinforce neoliberal agendas contributes to similar scholarship on race and power, and suggests how law enforcement plays a role in perpetuating health inequalities through enforcement done with notions of penalizing criminally deviant populations.

**Conclusion: Belied Care**

Interior immigration enforcement in places such as Atlanta has resulted in feelings of fear and trauma among some undocumented Latino immigrants, serving as a type of governance based off criminalization processes that are informed by neoliberal notions of deviance. By governing through fear, undocumented immigrants can be fashioned into ideal neoliberal citizens who do not make demands for services and seek alternatives for services other than seeking aid from the state, including medical care. Moreover, forms of policing such as roadblocks that directly impact Latino communities and Latinos seeking care hinder access to existing services, such as mental health counseling and substance abuse services. In times of heightened sense of vulnerability to deportation, mental health concerns for undocumented immigrants can be especially significant (Aroian 1993), and although services may exist, they are made difficult to access by police enforcement. Although access to mental health services is often challenging for undocumented immigrants, in Atlanta, mental health services exist but made artificially difficult to access through the creation of enforcement barriers.

The existence of mental health services but constrained access services due to policing, and visibility and number of Latino clinics that purportedly offer services to Latino patients but may be exploitative in nature, reveals a controvertible medical landscape in which health
services for the undocumented Latino population are ostensibly available but treatment received may be unobtainable or substandard. This belied care, or care that exists but disguises another reality, deserves increased research attention that must focus on the relationship between purported services and law enforcement activities. In many ways, law enforcement itself becomes an entity of belied mission, ostensibly existing for public safety and welfare but undermining the safety and wellbeing of many undocumented immigrants and their families. This becomes especially clear in the following chapter, in which I describe the family-related impacts of immigrant policing in Atlanta.
CHAPTER SEVEN:
FAMILY-RELATED IMPACTS OF IMMIGRANT POLICING

Introduction

On a particularly cold but sunny Thursday morning in February, I drove an hour north of Atlanta to a small town to meet Verónica, whose cousin was a GLAHRiador and put us in touch. Verónica, a tall, thin woman in her mid-20s, has lived in the US for thirteen years. She came to Georgia with her aunt and uncle and lived closer to Atlanta until about five months before we met, when she moved to a town whose rural-to-suburban transition was underway, aided by its proximity to the highway. Verónica explained that she moved to avoid police in her former neighborhood because she had been arrested for driving without a license.

I was coming from work one day a police officer pulled me over. I wasn’t speeding or anything, but he pulled me over and took me to jail for not having a license. They let me out of jail, but I learned that I supposedly had an order for my arrest since 2011 from getting stopped at a checkpoint. When I was stopped at a checkpoint, they were checking to see if people were wearing seatbelts, and I was giving a ride to a woman and her kids that weren’t wearing seatbelts, so they pulled me over, but they didn’t take me to jail that day. The officer was Hispanic and he told me they wouldn’t detain us, but he would just give me a ticket. So after that, I got an attorney and the attorney told me that I didn’t have to go to court or anything, but this is what I had the order for arrest for that I didn’t know about.

Stunned by Verónica’s experience, I asked if she met with the attorney who helped her with the case. “I went to see him and I told him that police told me I had an order for arrest,” she explained.
I said “look, I know I owe you money,” because I was making payments, and I told him they deported the father of my children so I’m alone and I have no money, but when I can work again I’ll keep making payments. And so I said, “a warrant for my arrest, is that true?” and he said “no, your case is already closed; you don’t have to do anything except pay me,” and I said “okay.” After I left his office, I learned yes, I have had an order for arrest since March of 2011. So I was sent to Cobb County and they let me out, but right now I can’t drive or anything because I was told if I got caught again for driving without a license they would take me to immigration. So I don’t drive anymore.

Interested in learning about how Verónica managed to take care of her three young children by herself, I asked about what happened to her children’s father.

“Their father is in Mexico—they deported him,” Verónica answered.

“Oh. I’m sorry. What happened?”

A police officer got him…for not having a license, they got him, and immigration got him. We paid the immigration bond—they charged us $7,500 for him to leave, and we paid it and he left, but after that, ICE is supposed to send a court summons, but they never sent it and later when they took him to jail again, the lawyer we got said ICE made a mistake and didn’t mail the summons. So the lawyer said with that bond we had paid he could leave jail, but the girl who did us the favor of signing the bond, because the person that signs has to have papers, she no longer could help us, so they sent him back to Mexico. The lawyer said he could maybe fix his papers since he had been here for 19 years, but he wasn’t able to and now he’s back in Mexico.

“Is he going to try to come back, or do you think he’ll stay there?”

“He’s already married there, so who knows. He says he wants to see his children but I told him I wasn’t going to send them because they are too young, and he said he thinks he can see them later, but who knows. We talk on the phone so at least he can talk to his children, but who knows if he’ll ever get to see them again.” Verónica then explained she was trying to apply for temporary relief from deportation granted through DACA so that she can avoid being
deported, but is having trouble meeting the requirements. “They ask for proof that I got here at 14 and I don't really have proof because I worked in restaurants and they paid me in cash, so I’m going to see if one restaurant owner will write me a letter, but I haven’t found him. And they ask that you enroll in school but I’m looking for a school close to here because I don't want to drive.”

“What do you do then if you need to go somewhere?” I asked.

“I ask my boyfriend to take me, or I get a ride,” Verónica answered. Verónica met her current boyfriend, Antonio, at a dance club. Antonio has a valid driver’s license from another state that he shows if he gets pulled over. “One time they pulled Antonio over and asked for his license, and he showed it to the police and the officer said ‘okay, well if you’re going to live here you have to get a license here;’” but they don't give us one here! They don't want us to have a license!” As Verónica explained how immigrant policing reduced her willingness to drive, I asked how she was able to do necessary tasks or leave the house.

“So what do you do—you have children and you cannot drive, what can you do if need to leave the house for something?”

“You stay put,” Verónica responded.

“Isn’t that difficult?”

“Very difficult—you’re unable to work and unable to do anything. You can’t safely go out into the street because you think they’re going to pull you over. I used to drive, in all these years I was driving and I had never been pulled over except that one time and then that checkpoint where they checked for seatbelts.” Verónica then provided more details about the day she was stopped at the checkpoint. “They stopped me because I was borrowing a car and I didn’t know it didn’t have a [valid registration] sticker, so they arrested me and took me to jail for not having a license and for not having the sticker.” Verónica continued by explaining how
immigrant policing limited her mobility and impacted her ability to take her children to receive necessary care, echoing stories like those of Martina in the previous chapter, who stressed her inability to leave the house for reasons other than absolute necessity. “I can’t just go to a store if I want to. There are many places I need to go but can’t if I don't have a ride. Like yesterday, I needed to go to the lawyer and I didn’t have a ride. Sometimes my boyfriend takes me but sometimes he can’t, and it’s hard to walk around here, and I have children who have appointments, so I can’t get to the pediatrician or the dentist either.”

Verónica’s children are US citizens and are eligible for Medicaid. Despite their eligibility, Verónica has started receiving benefits for her children because she cannot afford to pay their medical expenses on her own and in the past did not feel the need to seek benefits because of her former partner’s income. “I didn’t want to get Medicaid for them because their father was making good money, but right now, as I said, I’m all alone...the father of my children was deported.” Although Verónica asks friends for rides to make appointments for her children, complicating her situation is the lack of public transportation where she lives. “There’s no bus here. [Where we lived in Cobb County,] (she now lives in Bartow County) there was a bus and sometimes we would take the bus to Wal-Mart, but here, there are no busses.”

When I asked Verónica how she felt about the difficulties in taking care of children as a single parent unable to drive, she began to cry. “I just feel so much despair because I have no job and I have my children I have to look after.” Although Verónica has a boyfriend who provides for her economically, she explained feeling guilty for not being able to work. Continuing to weep, she explained, “My boyfriend helps me sometimes but it’s a big burden for him, paying for this house that’s too expensive, the car insurance, the bills, and everything. It’s really hard for him by himself, and I want to work, I tell him ‘I’m going to have to work,’ but he says ‘no,’ he expects
me not to drive, but you need to drive because you need to work. Sometimes it’s just so frustrating that you can’t—” Verónica, overwhelmed with tears, was unable to finish her sentence. “I have to care for my children;” she said, wiping the tears streaming down her face. “Their father was deported.”

After meeting Verónica and learning she was economically dependent on her boyfriend after the father of her children was deported, I became interested in how immigrant policing may disrupt family relationships. Although Verónica’s boyfriend was economically assisting her, I began considering how economic dependence in some immigrant families may create or contribute to unhealthy and potentially harmful relationships. Economic hardship plays a key role in intimate partner violence, and economic dependence on a partner is one of many factors that may be present in abusive relationships (Bornstein 2006). Accordingly, I began attempting to understand how immigrant policing had family-related impacts.

In previous chapters, I described how localized immigration enforcement formed a type of fear-based governance that shapes undocumented immigrants’ behavioral health and ability to seek health services. In this chapter, I focus on how immigrant policing has disrupted family lives and how family-related impacts represent an important aspect of immigrants’ resistance narratives to immigrant policing. As I will describe in this chapter, immigrant policing can potentially disrupt families in two ways: first, by separating parents from children, as demonstrated by Verónica’s situation, which leads to increased economic turmoil and perpetuates the threat of family separation that requires contingency plans in the event of parental removal; and second, by producing situations that exacerbate existing intimate partner violence or contribute to potential intimate partner violence.
Additionally, by focusing both on how immigrant policing impacts families and how such impacts are used in immigrant rights narratives, I demonstrate that the type of social violence occurring through immigrant policing is reproduced within families through family separation and physical violence. Social violence through policing disaggregates family connections and points to the way in which the violence of policing becomes internally operable in intrapersonal relationships among some undocumented immigrants in Atlanta.

**Family-Related Impacts of Immigration Laws and Family Violence**

This chapter draws from literature on family-related impacts of immigrant policing and research on immigrants’ experiences of physical violence within their homes. Focusing on the family impacts of immigrant policing can capture how adults understand the implications of immigration enforcement on their children and also captures children’s perspectives through adult caregivers and service providers. Although children were explicitly excluded from this research\(^{39}\), examining how immigration laws and policing affect them and their parents merits discussion as it demonstrates how fear-based governance through enforcement affects all family members regardless of immigration status and age.

**Immigrant Children and Immigrant Policing**

Although this dissertation did not initially intend to examine how immigration policies impacted undocumented children and families with young children of undocumented parents, family-related themes surfaced during my involvement with GLAHR and other organizations\(^{40}\). Moreover, childhood has become a central notion in immigration politics, best highlighted by the

\(^{39}\) This research was not initially designed to focus on children and was therefore not considered for IRB approval to involve children.

\(^{40}\) This process effectively highlights how multi-sited research can lead ethnographers into tracing a specific idea through different social spaces, which in this case meant social spaces surrounding Intimate Partner Violence (IPV), including intrapersonal relationships with family members and relationships with organizations, such as IPV service providers.
Obama Administration creating Deferred Action for Childhood Arrivals (DACA), announced while I was collecting data for this dissertation. DACA provides temporary relief from deportation and work permits for eligible undocumented immigrants who arrived to the US while they were children, like Verónica and her children’s father. The Obama Administration announced DACA in the midst of ongoing congressional and political debates about immigration reform that frequently describe children of undocumented immigrants as a desirable class of “potential citizens” whose only misgiving was being born to parents who crossed the US-Mexico border. Childhood therefore represents an important aspect of immigrant policing to consider, especially since an estimated 4.5-5.5 million children born to undocumented immigrants are US citizens (Dreby 2012; Zayas and Bradlee 2014), demonstrating that immigration enforcement has the potential to impact a large population of US citizens (Zayas and Bradlee 2014).

Recent research focusing on immigration enforcement and its impact on children describes how arrests, detention, and removal processes of undocumented immigrants impact children by creating “two classes of vulnerable citizen-children: exiles…and orphans” (Zayas and Bradlee 2014: 169). Exiles are children who leave the US with their parents, and orphans are those that are left in the US and cared for by others, including the child welfare system (Zayas and Bradlee 2014). Should Verónica be deported and her citizen children remain in the US, they would occupy the “orphan” category described in some immigration literature: separated from their parents due to having differing immigration statuses. Despite being associated with serious emotional and economic impacts for children (Barajas et al. 2008; Chaudry et al. 2010;
Leventhal and Brooks-Gunn 2004; Zayas and Bradlee 2014), parent-child separation continues as adult immigrants are deported from the US and their citizen children remain\textsuperscript{41}.

In many situations where parents are deported, the state may terminate undocumented parents’ parental rights and place children with foster parents (Andrapalliyal 2013), as demonstrated in cases such as State of Nebraska v Maria L (Zayas and Bradlee 2014). In 2012 alone, more than 88,000 immigrants who had at least one citizen child in the US were deported; although children may stay with US citizen relatives, more than 5,000 children in the foster care system are children of deported parents (Human Impact Partners 2013). Furthermore, in jurisdictions with 287(g) agreements, children in foster care are more likely to have a detained or deported parent than children in non-287(g) counties (Wessler 2011b: 6). In Georgia, the potential for children of undocumented parents to be in foster care and for parents’ rights to be terminated, like in the Nebraska v Maria L case, was confirmed to me in informal conversations with state agency workers, including a woman who worked for Georgia’s Department of Family and Childen Services (DFCS), who explained “sometimes you see that being undocumented is considered against the parent—it’s a liability, and the state will see that it’s not in the best interest of [the] child to be with an undocumented parent, so they put the children with foster parents.” Although DFCS officials claim documentation status is not a factor in determining whether parents maintain custody of their children, news reports document at least one high profile incident in which DFCS allegedly refused to reunite Latino parents with their children.

\textsuperscript{41} Adding to this concern is the related but different phenomena of former child arrivals being deported as young adults. In Atlanta, a 2010 high school graduate’s story made headlines when he was arrested for driving without a license after being struck by a drunk driver. Immigration and Customs Enforcement wrongfully deported him, and as he explained when we met, “brought [him] back to the country to be deported again the right way.” Beyond the absurdity of being deported and returned to the US only to be deported again, this undocumented youth’s experience highlighted a bigger concern for undocumented young adults who arrived to United States as children but now face the vulnerability of being “deportable” as adults.
because of the parents’ documentation status and language ability (Trevizo 2011a; Wessler 2011a).

Fear of being separated from her children was one of Verónica’s greatest concerns, as she explained that she wanted to work but could not drive because the risk of being apprehended by police was too great: “I know I need to work to provide for my children, but if I drive I can get arrested and deported, and I may never see them again.” Although impacts on children were not a research focus, implications of immigrant policing on children and their parents as part of a family unit emerged as a theme of my engagement with GLAHR and through conversations with service providers and immigrants. Similarly, intimate partner violence was not an initial focus of this research but became a theme that emerged out of interviews with women like Veronica and participant observation experiences Although Verónica never explicitly said she was in a violent relationship, I intuited discomfort from her as she discussed her boyfriend and scanned the road for his car every few minutes from her living room window. Additionally, her economic dependence on her boyfriend and financial desperation are economic risk factors for intimate partner violence (Abramsky et al. 2011; Stith et al. 2004).

**Intimate Partner Violence and Immigrants in the United States**

Intimate partner violence (IPV) is any type of violence against a current or previous spouse, boyfriend, or girlfriend that leads to any type of physical, sexual, or psychological harm (Modi et al. 2014). As a global problem that can exist in any relationships, IPV affects men and women in opposite and same-sex relationships (Modi et al. 2014) (Bostock et al. 2009; Greenwood et al. 2002; Tjaden and Thoennes 2000b; West 2002) and is associated with substantial economic and health-related burdens (Modi et al. 2014), including death, injury, disability, chronic illness, and mental health concerns (Ellsberg et al. 2008; Plichta 2004; Wong
and Mellor 2014). IPV research among immigrants has suggested that violence may increase after immigrating to the US (Tjaden and Thoennes 2000a), existing violence may be exacerbated by conditions related to immigrating (Menjívar and Salcido 2002), and some immigrants may not report violence to authorities because they fear having their immigration status discovered (Raj et al. 2004). Furthermore, language, economic, and social barriers may increase feelings of isolation among immigrants experiencing IPV, and immigrants may not be aware of services available for violence (Modi et al. 2014). IPV-related concerns, such as depression, may be exacerbated by synergistic impacts of immigration and minority status, as recent research on undocumented Latinas reveals higher rates of depression than their non-Latina white counterparts (Rodríguez et al. 2009).

Among undocumented immigrants, IPV situations may be complicated by issues surrounding legal status, particularly in mixed-legal status relationships (Parson et al. 2014). Furthermore, fear plays a prominent role in the IPV context for undocumented immigrants, perhaps more so than among others who experience IPV as fears of deportation may serve as barriers to seeking IPV services and abusers use immigration status fears as methods of control and violence (Abraham 2000; Erez et al. 2008; Parson et al. 2014; Salcido and Adelman 2004). Although federal legislation for addressing IPV exists, current legislation inadequately addresses the needs of immigrants at risk for or already experiencing IPV.

In 1994, Congress passed the Violence Against Women Act (VAWA), which provides funding for numerous IPV-related projects and increased penalties for sex offenders (Modi et al. 2014). Since its passage, IPV victimization rates have declined and intimate partner homicides have declined for both men and women (Modi et al. 2014). When VAWA passed in 1994, it allowed undocumented immigrants whose citizen spouses or relatives used their immigration
status as a form of abuse to circumvent required sponsorship procedures and petition for legal status and suspension of deportation (Conyers 2007; Davis 2004). These options were preserved even after immigration changes made by IIRAIRA took effect, but VAWA failed to provide protections to undocumented immigrants in IPV situations with non-married partners who were US citizens, immigrant spouses, and other groups (Conyers 2007). Changes to VAWA in 2000 addressed these shortcomings in part through Title V of VAWA, the “Battered Immigrant Women Protection Act of 2000” (Abrams 2009).

Title V of VAWA addressed shortcomings in previous versions of VAWA by creating U visas: temporary visas issued to victims of specified violent and coercive crimes who assist with investigating or prosecuting criminal activity. The visas grant work permits and allow immigrants to stay in the US for up to four years (United States Citizenship and Immigration Services, 2013 #2027) and provide potential for receiving permanent resident status (Davis 2004). Although U visas were created to assist law enforcement with prosecuting crimes such as human trafficking and domestic and sexual violence, only 10,000 U visas are granted each fiscal year (United States Citizenship and Immigration Services 2013), limiting the number of eligible applicants and potentially undermining the alleged purpose of the statute. When VAWA was recently reauthorized in 2013, it was amended to include protection of same-sex couples, trafficked persons, and Native Americans, but the reauthorization failed to expand the number

---

42 See the US Immigration Support page for more information: [http://www.usimmigrationsupport.org/visa-u.html](http://www.usimmigrationsupport.org/visa-u.html).

43 VAWA did not initially provide protections to Native Americans if abuse happened on tribal lands. For more information see: Singh, Shefali 2014 Closing the Gap of Justice: Providing Protection for Native American Women through the Special Domestic Violence Criminal Jurisdiction Provision of VAWA. Colum. J. Gender & L. 28:197-197.
of U visas granted per year or increase research investment into examining IPV among immigrants (Modi et al. 2014; Singh 2014). The growing number of immigrants living in the US and data indicating a gap between minorities experiencing and seeking services for IPV (Rodríguez et al. 2009) points to a pressing public health issue demanding anthropological inquiry.

Ethnographic research focusing on connections between legislation and IPV have critiqued notions of passive victimhood and situated violence within broader social contexts, including colonial legacies, gendered relationships, transnational familial arrangements, and challenges unique to rural settings (Abraham 2000; Adelman 2004; McGillivray and Comaskey 1999; Merry 2000; Websdale 1997). These contributions to IPV literature demonstrate that suggestions to “improve women’s status” along with reducing norms of violence and addressing influents such as poverty and alcohol use (Jewkes 2002), ignore deeper backgrounds of IPV and are rooted in a US perspective of IPV (Adelman 2004). Further linking social factors to IPV, anthropologists examining this topic have also documented connections between policy and IPV organizations, drawing connections to anti-violence coalitions and a neoliberal political economy of decreased violence prevention resources (Wies 2011). Furthermore, ethnographic work on violence underscores how social institutions play a role in normalizing violence, as Julia Hall demonstrates in observing violence among middle-school youth (Hall 2000).

Existing ethnographic research thus reveals how external policies and institutions provide contexts for violence. Adding to this body of literature, in this chapter I examine how immigrant policing and institutions of immigration enforcement in Atlanta contribute to IPV.

\[44\] VAWA currently funds 24 grant programs, including programs focusing on sexual assault, legal assistance for victims, court training programs, engage men in prevention efforts, tribal sexual assault and tribal assistance programs, and others. See the Department of Justice Website for more information: [http://www.justice.gov/ovw/grant-programs](http://www.justice.gov/ovw/grant-programs).
Problematically, a great deal of intimate partner and family violence literature focuses on heterosexual couples and assumes unquestioned heterosexuality and proscribed gender roles in which women are victims and men are abusers. Recognizing this shortcoming in literature on violence and reporting on data collected, this chapter also limits discussions of physical violence between men and women in which women were described as recipients of abuse. This limitation is not meant as a research oversight, but is instead responsive to the data collected and reflects its limitations. Not paying attention to IPV among non-heterosexual populations is a limitation of access to the organizations I found in Atlanta, as the IPV organizations I spoke with primarily serve heterosexual couples. The limitation of the organizations therefore extended into the limitations of the research.

**Immigrant Families and the Resistance Narrative**

Like Verónica, many immigrants I met in Atlanta described concerns over being deporting and possibly losing their children or discussed severe economic hardships resulting from spousal deportation. As one woman, Estrella, explained: “My husband was deported and now I have to care for my children by myself. I don't work or drive because there are police, and I don't know what to do.” Estrella further explained she felt her children deserved to be with their father. “They deserve to have their father here with them. They’re from this country and they deserve to grow up with their father,” Estrella tearfully asserted. Although Estrella found assistance with rent and bills through her church, she was unsure how she would continue to support herself. Her story, along with Veronica’s, raise questions about single-parent households where one partner has been deported and coping strategies for such situations, which may include not working in order to ensure children have at least one parent to come home to. Stories
like Verónica’s and Estrella’s were commonly discussed in comité popular meetings and often served as part of the immigrant policing resistance narrative in GLAHR.

“Children deserve to be with their parents,” Inés would explain in discussing problems with deportation and immigrant policing. “These laws are destroying our families and they are destroying our communities.” Family separation narratives were often used in resistance messages and specific GLAHR activities, including a political bus tour to legislators’ offices and popular theater events. Both sets of events emphasized the family impacts of immigrant policing, especially the bus tour titled “Keeping Families Together.”

“Keeping Families Together” Bus Tour

On March 5th, 2013, I met Inés and other GLAHRiadores at Plaza Fiesta to join them on the “Keeping Families Together” bus tour. The bus took GLAHRiadores and leaders from GLAHR, GIRRC, and the National Korean American Service and Education Consortium (NAKASEC)45 to the offices of U.S. Representatives Robert Woodall and David Scott, and Senators Saxby Chambliss and David Scott. At each stop, Inés, Don Teo, and a representative of NAKASEC met with legislators to urge them to support immigration reform. While they met, I joined GLAHRiadores and GIRRC members in holding signs outside of legislative office buildings as local news media snapped pictures and interviewed the small number of bus riders joining the tour. As the name of the bus tour suggested, the purpose of meeting with legislators was to convince them to pass legislation that would halt deportation and subsequent family separation.

45 Although NAKASEC collaborated with GLAHR on large marches and rallies, the two organizations did not frequently work together during my fieldwork, and one NAKASEC leader explained this event was to help raise awareness about how Asian immigrant families are also affected by reunification challenges, not just Latinos.
In asking Inés how successful she thought the meetings with legislators were in reaching the goal of immigration reform to stop separating families, she was largely unsure of what the impact would be. “We’ll see what happens. They haven’t done anything for immigrants yet and it’s time—we are tired of waiting. In the meantime, we will continue to organize the community. What’s happening to families is wrong!” Although much of GLAHR’s work entails community organizing through popular education events, political demonstrations, and “know your rights” awareness actions, several events I participated in had a family focus with the intention of inspiring political action. These events not only included the Keeping Families Together bus tour, but also two teatro popular, or popular theatre, events.

Teatro Popular

Through working closely with GLAHR, I assisted in organizing and participated in events GLAHR organized, including teatro popular events, a type of “theatre of the oppressed” in which marginalized populations can use theatre to build social networks, draw attention to
social injustices, and learn and share strategies for overcoming various forms of oppression (Bates 1996; Boal 2000; Faigin and Stein 2010; Halperin 2002; Howard 2004; Sanders 2004; Wernick et al. 2014). One of the GLAHRiadores, Alfonso, led the _teatro popular_ endeavors, which were usually performed in Plaza Fiesta on a weekend. My first performance involved me playing the role of George W. Bush, where I spoke gringo Spanish in an exaggerated southern American accent through a mask of the former president. While this performance was not necessarily focused on family-related impacts of deportation, it featured one scene in which a child’s parent was arrested while she was driving.

![Figure 15: Playing George W. Bush in a _teatro popular_.](image)

For the second _teatro popular_ I participated in, I took the role of a young boy in school whose friend, Maria, did not show up to school that day. As the _teatro_ unfolded, audience members learned that Maria did not come to school because her father was stopped by a police officer and arrested for driving without a license. Once the 10 minute-long play ended, audience
members were encouraged to write to Congress to stop deportations, with the help of
GLAHRiadores who supplied pens and paper. Despite the intention of having children write
letters to Congress, the children watching the teatro instead wanted to draw and play on the
jungle gym in Plaza Fiesta where we performed. GLAHRiadores and I instead then asked parents
to write letters.

Figure 16: Rehearsing the scene in the first teatro popular in which a young girl's mother is
arrested while driving her to school.

These performances highlighted to me and to audiences how immigrant families could be
separated through immigrant policing: an arrest made through a checkpoint led to an arrest for
driving without a license, which led to an ICE hold and eventual detention and deportation made
possible through a local arrest in a Secure Communities jurisdiction. Although numerous
conversations with GLAHRiadores made it clear how immigrant policing could separate families,
during one of our rehearsals for the teatro involving the story of Maria the immigrant policing
impacts of immigrant policing became increasingly clear. At this rehearsal, Inés asked if
everyone had a plan for their children in case they were arrested.
“We’ve talked to [our daughter],” one GLAHRiador said, “but nothing is written.”

“It’s very important you have these things in writing,” Inés pleaded. “What if you and your wife are both arrested, what happens to your children?”

“Alexis knows that if we don’t come home where she should go,” Mari, a GLAHRiador with a five-year old daughter named Alexis, said. “She knows where to find the papers that say who she should stay with if we get sent back.”

“It’s very important to do this if you haven’t already,” Inés explained. “Who do you want making decisions about your children? It’s very important!”

“Alexis,” one GLAHRiador called to Mari’s daughter. “Do you know where to go if something happens to your parents?”

“Who do you stay with?” Mari asked, looking to Alexis, “If your father and I don’t come home?” Eyes wide and maintaining her nearly always-present grin, Alexis responded:

“Mi Tia Ariana!”
“That’s right!” Mari exclaimed. Just as Mari, her husband Jose, and Alexis had talked about potential plans of care if Mari and Jose were apprehended by police or deported, so did other undocumented immigrants I met in Atlanta. Family contingency plans were often discussed and occasionally put into writing.

**Threat of Police and Contingency Plans**

As countless stories I heard while in Atlanta confirmed, like those of Verónica and Estrella, immigrant policing translated to direct family impacts through parent-child separation and parental deportation. Many immigrants I met worried about or planned for possible deportation scenarios, including Anita, a mother of four. When I met Anita in her home, she welcomed me inside while she finished cooking a meal.

“*Siéntate, por favor,*” she said, ushering me into her kitchen and gesturing at the table. “Go set the other table,” Anita instructed one of her daughters, who then brought a folding table out from another room and covered it in a white table cloth. A few minutes later, Anita began serving plates of rice and beans with tortillas with grilled pork and vegetables. As we sat and ate at a small table by the kitchen, Anita’s children, aged 12-22, ate next to us at the other table.

Anita arrived to the US in 1999 with her husband and three of her children. She initially worked a variety of hospitality jobs, including working as a dishwasher in the Westin hotel in downtown Atlanta, housed in the iconic Peachtree Tower. When she and her husband Carlos arrived to the US, Carlos got a driver’s license but was unable to renew it when it expired because of changes made to drivers’ license laws that required proof of legal status. After the introduction of 287(g) and Secure Communities into the Atlanta area, Anita explained that Carlos feared leaving the house because he did not want to drive.
“He started to panic,” she explained. “He didn’t want to drive anymore.” Anita told Carlos that they had to drive and continue providing for their children.

“We’re here, we have to go out. And he said ‘the police that are here in front of our house, it’s possible they’re going to pull you over.’ And I told him we have to drive, we have to leave to go to work, we have to leave to get food for the children.” Anita and Carlos disagreed about whether or not to stay in the US, and Carlos ultimately decided to return to Mexico on his own in December of 2011 because he feared getting arrested by police.

Daily driving is a risk for Anita and she is unsure what will happen when she leaves the house. “I leave for work but I don't know if I'll return. What will my children do without me?” Anita fears what may happen to her children if she is deported because she is the primary caregiver and worries they will not know how to care for themselves. “I remember a time I got sick and went to the hospital and my children didn’t eat because Carlos didn’t know what to make and didn’t take them to a restaurant. They didn’t eat! I was in the hospital for three or four days because I had a seizure.” During her stay in the hospital, doctors informed Anita that she had parasites in her brain from eating undercooked pork.  

This experience made Anita realize that her children were dependent on her.

“I can’t get sick and I can’t get stopped by police—what are my children going to do? If anything happens to me it’s my children I’m most worried about. And they’re always telling me ‘don't work so much, eat well, don’t get sick!’”

Although Anita fears what may happen to her children if she is stopped by police and arrested, she recognizes risks involved in driving.

---

46 Cysticercosis is an infection caused by consuming food or beverages contaminated with eggs of the *Taenia solium* tapeworm. For more information see: [http://www.cdc.gov/parasites/cysticercosis/](http://www.cdc.gov/parasites/cysticercosis/)
“I’m very Catholic,” Anita explained, noting that she says a prayer before driving and recognizes she cannot control whether she gets pulled over: “If a police officer is going to stop me, they’re going to stop me.”

Like Anita, other parents expressed concerns over what would happen to them if they were deported. Silvia, a mother with two children, explained “I say goodbye to my children every time I leave the house because I know I may not see them again.” Silvia further explained that she, like other parents, had prepared instructions for her children if she were arrested.

“See that table over there,” Silvia said to me while we sat in her home, gesturing to a small console table with drawers. “There’s a folder in there with instructions for where to go and who to contact if I don’t come home. My daughter knows that if I don't come home that she should take that folder and go to the neighbor’s house.”

Although some parents prepared plans for children in the event of their deportation, some children felt understandably anxious about potential deportation possibilities. As one service provider explained, “Children are so anxious and so afraid their parents are going to get deported that they’re afraid to go in the car. I see kids drawing pictures of their dads getting arrested, and kids aren’t doing as well in school because they’re anxious and worried about what’s going to happen to their mom or to their dad while they’re in school.”

For some children who witnessed a parent’s arrest anxiety also coincided with personal blame, as another service provider explained. “What we see is that the fear leads to anxiety. So with the younger kids we see a lot of reporting of the headaches and stomachaches, a lot of the physical stuff, which is the way that they’re internalizing some of the anxiety and the fear.” This service provider continued to explain that fear resulted in children not wanting to leave their parents during the day in order to go to school: “We’ve had kids who are afraid to go to school
because they’re afraid their parents might not be there by the time they get back; for a lot of families when they get pulled over it wasn’t at 3 o’clock in the morning, it was on the way to the grocery store for an imaginary taillight that went out…” Thinking of one person in particular, the service provider explained how some immigrant children may blame themselves for their parents’ arrests and deportations. “I know one youth in particular who blames herself because her mom got pulled over after she asked her mom to take her to the grocery store to pick out a birthday cake for her brother, or her dad, or somebody, and her mom got pulled over on the way to the grocery store with her daughter and long story short the mom ended up getting deported.”

According to this service provider, the sense of blame translated to this one girl attempting to replace her mother’s household role because she felt responsible for her deportation. “So this child ended up dropping out of school in order to help take care of family and kind of replace the mom and her role. She blamed herself for asking for the cake and she thinks she caused it. It’s just sad because it wasn’t her fault, but you saw the impact on her life and now she is trying to get a GED.” Thinking more globally about immigrant policing and its impact over time, the service provider added that these anxieties continue as children age into adults. “It’s just frustrating at times to see this all happening—the kids are suffering and they keep suffering when they’re adults.” As these accounts of children’s concerns highlight, both children and adults can be preoccupied with deportation concerns. Just as family separation was on the minds of many family members, it was a constant topic for potential political action for GLAHR, as demonstrated by teatro popular events and a letter-writing campaign in December.

**Holiday Wishes for Stopping Deportation**

In addition to the two teatros, GLAHR also organized an event focused on families and children titled “A Wish for the Holidays.” The goal of the event was to get children to write
letters to Congress to stop deportations and stop “breaking up families.” To get children to write letters, one GLAHRiador dressed as Santa and had children sit on her lap and tell her what they wanted for Christmas. Before seeing Santa, however, children were required to write letters, and playing the role of Santa’s elf, I was to ensure that children had completed their letters before sitting on Santa’s lap.

“It can’t be like last time [at the teatro event] where they just colored [and didn’t write letters],” Jazmín, a GLAHR employee said to me. “They need to write the actual letter this time!” To ensure children wrote letters, Alejandra and other GLAHRiadores stood with them and helped them write.

“Dear Congressman,” Jazmín instructed children to write. “This year for Christmas all I want is for families to stop being broken apart. Please pass immigration reform…” Next to Jazmín, another GLAHR employee guided another child writing a letter.

“Dear Congressman,” Zoe repeated, “Please stop separating families. This Christmas I want to be with my dad…”

Once children completed the letters, they received a raffle ticket, and I took their tickets as they waited in line to meet Santa. As more children lined up for Santa, Zoe left her letter-writing post and began painting faces. By the time the event ended, we had collected nearly 70 letters. “Not bad!” Jazmín exclaimed. The letters were eventually mailed off to individual members of Congress along with other letters that GLAHRiadores’ children had written and hand drawn pictures.

My experiences with GLAHR and interviews with undocumented immigrants point to how immigrant policing disrupts family lives. Immigrants like Verónica and Estrella feel heightened economic concerns and women like Mari develop contingency plans and ensure her
children are aware of what to do in case she and her husband do not return home from work. Participant observation experiences also point to how family impacts were used in resistance narratives, especially in events such as the “Keeping Families Together” bus tour. In addition to immigrant policing disrupting families through parental deportation and perpetuating fear of deportation that necessitates contingency plans, immigrant policing also impacts undocumented immigrants in overtly violent ways. As I discovered through participating in Doraville *comité popular* meetings and through other organizations, immigrant policing may contribute to IPV or exacerbate existing violence.

Figure 18: Playing Santa's Elf during a GLAHR letter-writing action.

**Fear of Police and Family Violence**

**IPV Emerges as a Research Topic**

My interview with Verónica led me to consider how family separation from immigrant policing led to economic hardship and resulted in economic dependence on a partner that could be potentially be unhealthy. Although I considered the relationship between economic
dependence and IPV after meeting Verónica, I began contemplating IPV and immigrant policing in the early months of my fieldwork, when I began participating in a comité popular. During one of the many Doraville comité popular meetings I attended, I tried to arrange an interview with Leticia, a woman with a teenage daughter and young son. Leticia frequently went to meetings and lived across the parking lot from Doña Julia.

“You should talk to Nolan,” Julia insisted one evening, as we all stood in the parking lot outside of the apartment complex’s basketball courts where we met at a group of picnic tables. “He is learning about all the hardships we face—all the checkpoints and people being arrested, all the families being broken up. You should talk to him!”

Julia had been trying to arrange an interview with Leticia for me for several weeks, and Leticia typically came up with reasons why she could not participate in an interview, such as not knowing a good time to talk. Again, Leticia looked anxious when Julia insisted she speak with me.

“Everything you say is confidential,” I assured Leticia. “But if you really don't want to, it’s okay, there’s no problem! I don’t mind at all.”

“It’s true!” Paula exclaimed. “He tried to interview me once and I didn’t want to do it and we still talk and see each other and it’s fine!”

Paula had rejected my interview attempts because she was not comfortable with the IRB documents and did want to have anything she said recorded. Months after I requested an interview with Paula, while we were chatting during a comité popular meeting, I learned her husband had been arrested for driving without a license and she was taking care of their three children alone. She later told me that she was paranoid about her information somehow getting to immigration authorities.
“My husband doesn’t really like people coming over,” Leticia explained.

“Your husband?” Julia asked. “It’s okay, Nolan will just talk to you.”

“It’s okay, if you don’t want to you don’t have to!” I began to feel that Leticia was being coerced and wanted to find a way out of the situation. “I’m really hungry anyway, so I need to head out and grab dinner.”

Julia turned to me. “Leticia can make you pizza,” she said. “Nolan likes pizza,” Julia said, turning back to face Leticia. “You should talk to him. He’s recording the story of what’s happening to our community.”

“I just need to talk to my husband first,” Leticia said with a concerned expression.

“It’s fine, I have to go anyway,” I explained.

“Okay, talk to your husband and then next week you can talk to Nolan,” Julia said definitively.

“Okay, next week if my husband says it’s okay,” Leticia responded.

“Yes, next week, and you can have pizza,” Julia confirmed. The following week the comité met and after the meeting I followed Leticia to her apartment. She seemed anxious, and I assumed she had not yet gotten comfortable with me.

“You really don't have to talk to me if you don't want to,” I explained.

“No, it’s okay, and like Julia says, it’s helping our community. Someone should know what we go through.” As I followed Leticia into her apartment I was struck by the messiness that starkly contrasted with Julia’s apartment. She instructed me to sit at her dining table and disappeared into the kitchen.
“You like pizza?” She asked, peering from behind the doorway that led into the small galley kitchen and breaking the uncanny silence in her apartment that was maintained even though her children watched the television.

“Yes, but you don’t need to make anything—I’m okay,” I answered, getting up to see if I could help with anything.

“It’s okay,” Leticia responded, taking a frozen pizza out of her freezer and heating her oven. “Go sit.” I returned to my seat and heard cardboard separating and pizza being placed onto a baking dish. Leticia returned to the table where she sat across from me. As I began the interview Leticia’s children started playing a game. Their laughter disrupted a dog I had not noticed, and I jumped when I heard a bark from what I had thought was an empty dog carrier against the wall.

“Shhhhhhh,” Leticia whimpered, frowning at her children. As the dog continued to respond to the children’s noise, Leticia opened the carrier and repeatedly told her children to be quiet even though the noise level was hardly disruptive to our interview.

“It’s okay—this recorder will still pick up what you say,” I explained. Confused, Leticia looked at me.

“The noise is okay—they don’t have to be quiet,” I assured her. As we continued our interview Leticia interrupted her children’s game and had her youngest child come sit on her lap, where he restlessly climbed over her or stared into the room while fidgeting. Not long after he sat on her lap, a man appeared from the hallway leading to the two bedrooms and one bathroom. As he appeared at the threshold of dimly lit doorway, he said nothing and scowled. Leticia looked at him as he looked at me, and I stood up and introduced myself.

“I’m Nolan, the student and volunteer with GLAHR,” I said, extending my hand.
“Manuel,” the man answered, shaking my hand and looking over at Leticia.

“I’ve got him being quiet now,” Leticia said. Manuel nodded, and disappeared into the dimly lit hallway.

“My husband,” Leticia explained. Suddenly our interview took an entire new meaning to me. I no longer felt responsible for the heavy air and awkward feeling I had in the suffocatingly silent, dimly lit apartment. Although I had no evidence for my intuition, I sensed Leticia was more than afraid of police, and as she told me she seldom left the house and that only her husband left home, I began to feel her relationship with Manuel was not positive. After we ended our interview, and left her apartment confused about her home life, I began wondering if Doña Julia and others in the comité knew or suspected anything that made them alarmed about Leticia’s relationship. Combined with an injury Leticia sustained to her face several weeks after we spoke, which she attributed to her son accidently hitting her in the eye, I became more concerned that Leticia was experiencing physical violence at home.

My experience with Leticia and Verónica led me to seek out IPV organizations in part to provide information for the two women and to also learn more about how immigrant policing played a role in IPV. In searching for resources for Leticia and Verónica, I found two organizations that provided IPV services to undocumented immigrants: the Partnership Against Domestic Violence (PDV) and Caminar Latino. PDV provides housing, legal advocacy, a crisis hotline, and various community outreach services and Caminar Latino focuses on support group and intervention services. Further differentiating Caminar Latino from PDV is Caminar Latino’s family-based approach to prevent violence from continuing in homes. Through a family-based service providing perspective, Caminar Latino meets with entire families and separates men, women, and children, into support groups and counseling sessions. For one of the organization’s
leaders, Sofia, this is one of Caminar Latino’s strengths. “Working with each part of the family, we’re able to have a better idea about what’s going on because the dad may lie and the mom may not be completely up front, but the kids will be like ‘oh no, they were just fighting a few minutes ago in the parking lot,’ so that’s where it comes in handy.” In addition to checking in with each family member about violence, Sofia noted that having service providers for each population group was helpful in ensuring services could be offered smoothly. “With us having everything in-house in terms of having our youth advocate right next to the women’s advocate right next to the person who’s working with the man, you don’t have the same level of frustration of [people not replying] which is one thing I’ve heard from other domestic violence organizations.”

Although the organization takes a family-based approach, the majority of Caminar Latino’s clients are women. Annually, Caminar Latino serves 400-500 women, 50 men, and 200-250 children. Children participating in Caminar Latino’s services are divided into groups based on age. One of the older children groups, which comprises high school-aged children, conducted an ethnographic study on the impact of immigrant policing on their families and presented their findings at national conferences. I was also able to hear firsthand from the high school students who worked on the report and presentations about their experiences in feeling targeted by police when I was invited to join a group discussion during one of Caminar Latino’s group nights. The students shared that they felt immigration laws reflected racist policies and heightened household stressors leading to violence. I did not interview minors for this chapter, but participating in a Caminar Latino group discussion with the high school-aged adolescents corroborated other informants’ perspectives about the relationship between IPV and immigrant policing. Students in the group discussion explained that they felt immigrant policing made their parents more frustrated and more likely to fight, explaining that policing worsened the family’s financial
circumstances because it resulted in decreased mobility, and financial tension could result in violent arguments.

**IPV among Undocumented Latino Immigrants in Atlanta**

When I began exploring IPV as a research topic, I met Marta, who left her abusive husband in Mexico to find work in the United States. “It got so bad I had no choice but to leave the country with my kids,” Marta explained. Marta has lived in Atlanta for nearly a decade and became a resident after marrying her second husband. She currently works for an IPV organization and uses her experience to guide clients she works with. “I went through what they’re going through and I know how they feel; I know from experience. So I can advise them and let them know what is the best thing to do, so they listen to me. I always tell them, ‘you know I was like you in Mexico. Here you have options; here you have a restriction order. In Mexico and Honduras they don’t have restriction orders. Here you can go to a shelter.” In my conversations with Marta, I learned how undocumented immigrants may face unique challenges related to IPV, such as social pressures that may not exist in other populations.

Marta described how significant social pressures to maintain a positive reputation within the Latino community meant many women would not report violence. “Immigrants build a community and keep an attachment to their home country,” Marta explained. “Even if they’re really far away they never detach from them, and when they move here they move into the same communities and they are so isolated because of language and everybody’s going to the same place, the same church, and everybody knows each other.” Although a sense of community could be considered an asset for overcoming interpersonal forms of violence, Marta understood a small social circle as a cause for concern since it pressured some women into not reporting violence. “They think, if I do that to him [call the police], my community is going to exclude me.”
situation is worsened through threats, Marta continued. “Men will say, ‘If you do this, if you do that, I’ll tell everyone you put me in jail.’ In the rural areas where they’re from, your dignity is more important. So many women will say ‘I was so afraid because he will say if I call the police that he’s going to tell everybody I was sleeping with another man and that’s why he beat me.’” The threat of damaging a reputation is so strong that Marta explained in some scenarios it outweighs the concerns over violence. “They would rather deal with the punches than have people think they are sleeping with another man because your dignity is important, and as a woman nobody can think bad about you.”

Although abuser coercion may be common in IPV circumstances, coercion and abuse may take different forms for undocumented immigrants in IPV situations. Abusers may specifically exploit fear related to immigration status and fear of child separation as a form of control, as a Lori, a PDV employee described. “In order to keep them in an abusive situation, abusers will use immigration status against women. They’ll say ‘they’re going to take your children away, and you’re going to be back in your country where I know certain people.’” Lori noted that these threats can be transnational and extend beyond the home. “We had a client who had connections in Mexico, so not only was [his partner] being threatened here, but she was also being threatened with her family--her parents in Mexico. So it was like ‘yeah I’ll get you deported, and over there I can certainly kill you.’”

Marta further echoed how transnational ties complicated some immigrants’ IPV experiences, noting that threats of violence extended over borders. “Most of the clients, the guys threaten them. ‘Oh you go to the police, I’m going to send somebody and hurt your mom or kill your daughter that you left in Mexico.’ And believe me they do.” Marta had just finished telling me about a man who burned down an apartment building with the intention of murdering the
woman he had directed his violence towards. Marta’s client did not believe the man would burn
down the building, and she was fortunate enough to escape the building before it was engulfed in
flames.

Just like the one with the apartment building, I have a client who said, “I didn’t believe him” [when he made transnational threats]. I had friends who said, “he’s just talking, you leave him he will do nothing,” but then they do. And they’ll say “the next time I called my mom, somebody went the house and shot the house,” or “somebody gave my uncle a really bad beating.” So they’re thinking “he means what he says, so I better go back with him.”

In addition to threats and physical violence, Marta explained that some immigrant women also
experience sexual violence in their abusive relationships. Sexual violence may result in
pregnancy, and Marta expressed frustration over racialized notions of Latina women having too
many children without recognizing that some women are unable to negotiate their sexual
participation. “People think that Hispanic people like to have a lot of kids. It’s not that, it’s that
they are being raped. They are being raped every day, they don’t want to have all these kids,”
Marta claimed.

Although Marta’s claim about rape may be an exaggeration, she included this explanation
as part of broader issues related to consenting to sex and receiving sexual health education to
avoid unwanted pregnancies. “This happens all the time,” Marta revealed. “People tell me ‘my
mom never told me about how you can get pregnant,’ or ‘my mom never told me how to prevent
getting pregnant, I didn’t want to get pregnant.’ I hear it all the time. [They will say] ‘I was
having a really hard time with two kids, I don’t want another but he would force me.’” Marta
added that notions of rape and consent differ culturally, and she learned this after moving to the
US. “In our countries [forcing a wife to have sex] is not illegal. I learned that here. I didn’t know
that here you are married and if the guy asked to have sex and you say ‘no,’ it’s no. In our
countries you have to do it because it’s your duty as a wife and I learned that.” Although Marta’s claims cannot speak for all notions of consent across the US, they provide the context for how some immigrant women may devise strategies to avoid sexual assault if they feel they cannot refuse sex with their husbands. Commenting on one of these strategies, Marta told me the story of a woman who would layer her clothing to make it difficult for her husband to undress her, using this as a way to avoid sex and pregnancy.

I have one client who would say that the way that she would prevent having kids was if the guy didn’t come back at Friday at 6 o’clock she knew that he would be drinking. She said every time he would drink he would have sex with her, so she I would put five pants on that night. So that worked, and that was her pregnancy prevention, because she didn’t know and she doesn’t have access to the services.

Even though some immigrants may experience sexual and other forms of violence, concerns over maintaining a good reputation and keeping family members safe in countries of origin persist. For this reason, Marta noted that when someone experiencing IPV calls the police it is usually a last resort. “So when an immigrant goes and calls the police it’s because she had it. It’s because of many, many, years. It’s not the first time; it has been many years… they get to the point where they don’t care about the community, they don’t care about the family, they don’t care about nothing but that they’re safe.” Marta understood this process as a form of survivorship rather than victimhood, exclaiming “So just imagine then: you are a survivor, you’re not a victim, you are a survivor.” A survivor/victim binary masks some of the political contexts behind IPV among undocumented immigrants, however, which Marta discussed in explaining why some immigrant women may fear calling police, especially in a climate of increased immigrant policing.
Not wanting to jeopardize their stay in the United States, Marta noted that “a lot of times women won’t call the police because they’re afraid they will get deported,” adding later that they feared their partners may also be deported. Just as fears of encountering an immigration enforcement regime altered immigrants’ willingness to seek certain health services, fears of deportation also impact whether immigrants report IPV. Expanding on this, some immigrants and service providers discussed ways how they felt immigrant policing exacerbated or contributed to IPV.

**The Role of Immigrant Policing in Intimate Partner Violence**

Interviews with organizations and immigrants revealed that some participants felt immigrant policing was directly connected to IPV. This connection was often described in the context of difficulty finding work due to the heightened presence of police and poor economy that kept people in their homes. As several interviewees discussed, economic constraints and perceived police harassment increased family tensions and contributed to existing IPV or the potential for IPV to develop. As Lori explained: “When it comes to domestic violence, [in the 2011 Georgia Domestic Violence Fatality Review Annual Report] they found one of the risk factors came from the idea of affecting gender roles of men, that they need to provide and be strong.” Further linking economics to gender roles, Lori explained the relationship between IPV and immigrant policing. “One of the risk factors was if he lost his job or they were going through some sort of health issue or financial problem. The situation here with undocumented immigrants, a lot of people are losing their jobs and being deported, not being able to drive to work, and it did affect domestic violence in the area—we definitely saw it with our clients.”

While the Georgia Domestic Violence Fatality Review Annual Report did not pay specific attention to immigrant families, economic hardships as a risk factor for IPV were themes
in conversations I had with Marta and Caminar Latino leaders. Marta elaborated on violence and economics by noting that abuse worsened following the implementation of 287(g) and passage of HB 87, even if violence occurred prior to immigrating. “I noticed that when the anti-immigrant law passed a lot of people were being laid off, and the violence—the calls we got increased like more than half—the calls, and calls, and calls,” Marta said, shaking her head. “I always ask ‘what was he angry about? Why was he angry?’ [And the client would say] ‘He says it’s because he can’t find a job; he says it’s because he was laid off.’ I mean, it’s an excuse. It’s a valid excuse, but it’s an excuse. So I noticed that.” Marta added that increased immigrant policing further translated to fears of having partners deported due to concerns over losing their economic contributions. “There’s more violence but more people aren’t reporting it because they love him, or [they say] ‘if I call the police he can get deported. At least he’s doing yard work and paying some bills.’ So it’s worse, it’s really bad. When 287(g) passed it was bad. [The males] don’t have a job, there’s a lot of violence, [no one calls the police], and the police report doesn’t get written down.”

Complicating concerns over economic dependency is the logic of certain deportation surrounding police notification of violence. Marta explained how many of her clients avoided calling the police because they were sure their partners would be deported, resulting in a loss of support for themselves and their children. “They’re very afraid about what’s going to happen if he goes to jail and if he’s more likely to be deported then who’s going to support them? Who’s going to feed the kids? And sometimes if they work, the money that they earn is not enough to provide by themselves…” Fear over losing economic contributions directly related to immigrant policing as Marta claimed her clients were certain an arrest would lead to deportation given Georgia’s immigrant policing practices.
A lot of the times we are able to press criminal charges but they didn’t want to. They will say, “no miss Marta, if he gets deported, or he goes to jail it’s very sure he will get deported.” Because they were deporting people in 2008 or 2009 for whatever, it didn’t matter. Driving without a license, walking in the street, it didn’t matter. So they would just want to do the restriction orders because the restriction orders are going to be through civil court so they don’t get criminal charges.

Concerns over lost economic contributions were therefore mediated by understanding the potential for deportation, motivating some immigrants not to report violence or to seek relief outside of criminal procedures in order to avoid risking their abusive partner’s deportation. Economic and deportation concerns may be present in many IPV situations but are heightened among undocumented immigrants who work in underground economies and whose economic instability is made more insecure by intensified policing efforts, such as checkpoints and roadblocks.

Echoing Marta’s claims and linking immigrant policing, lack of work, intimate partner violence, and alcohol abuse, Sofia from Caminar Latino explained she often sees men abuse female partners in frustration over lack of work and feeling police harassment. “Men are angry because they cannot find jobs,” she explained, “and the police are harassing them, and they’re drinking more because they can’t support their families, and then they take it out on their partners.” In explaining how men felt frustrated with police being more visible on roads and not finding work as easily, Sofia was quick not to condone abuse. “It’s not okay, but there are factors that are contributing to this problem,” she explained. One of the ways in which Caminar Latino is able to address these frustrations among men who may act violently is through group meetings. Through Caminar Latino’s family focus, men meet with other men in group settings, which Sofia said aided men in understanding the problems with violence. “If a man is complaining that he got so angry and frustrated because he hasn’t been able to find as much work because he doesn’t
have papers and because of the cops being out there, the man right next to him can say ‘I’m experiencing the same thing but you don’t see me taking it out on my partner.’ So then with us also working with the family, the men don’t see it as a punishment and hold each other accountable.”

Fear of deportation also impacted children of undocumented immigrants’ willingness to report crimes, as Sofia explained. “One of the things that we found out was the fact that kids were afraid to call the police because of the fact that they thought that could cause their mom or dad to be deported, so the kids were put between a rock and a hard place because they were afraid that their mom was going to either get killed or that their mom or dad might get deported.” As a result, Caminar Latino had to create safety plans that included permission for children to call police if necessary.

So we ended up having to create a new kind of safety plan with the parents. With mom we work on what kind of documents they need and all that kind of stuff where they should hide, stuff that the young kids don’t necessarily need to hear because they may let it slip, but then we also do kind of the joint safety planning where the kids kind of determine what they are responsible for. So if a fight breaks out then the oldest sibling, for example, is responsible for the younger siblings, taking them to a neighbor, doing this and that, whatever basically the family decides. The other thing is we basically meet with the moms beforehand and tell them one of the things that the kids need to hear from the mom was that it was okay for them to call the police if they thought their mom was getting hurt or killed because they need to hear it from the parents themselves that it was okay that they wouldn’t get blamed, that they wouldn’t get in trouble or anything like that.

Moreover, threat of police and potential deportation was occasionally used a tool of abuse. As Sofia from Caminar Latino explained, some couples used the threat of deportation as a type of violence. “We see it all the time. He’ll threaten to call immigration on her so you’ll see he uses her status against her, and she’s afraid to call the police because she’s afraid of being deported.
and never seeing her kids again.” This type of threat for deportation was especially concerning for mixed status couples. “If you see that she’s undocumented and he’s a citizen, there’s sometimes a lot of coercion there where he’ll threaten to call police on her and have her deported,” one IPV organization leader explained.

Although immigrant policing plays a role in not reporting crimes, Marta explained she is able to use immigrant policing advantageously. “I will ask, is he fearful of the police? And if they say ‘oh yeah he gets fearful when the police are behind him, he starts shaking,’ then I know maybe a restriction order is going to be good for keeping him away.” Recognizing how immigrants may be fearful of encountering police is thus used to the advantage of some immigrants experiencing IPV. Similarly, Sofia described ways in which abuse cycles changed when some immigrants found services through Caminar Latino.

Sometimes what will happen with the women is that all of a sudden they realize they are protected. [They think] “now I have somebody; I have not only the police, the court system, but I also have Caminar Latino,” so the women will start getting back at their partner because all of the sudden the controls kind of switch. So before when the violence breakout basically the male would take advantage and say oh nothing’s going to happen, but once the woman kind of feels like she has more control and more power in the situation, sometimes the woman will be like ‘I’ll call the police and there’s a chance you get deported.’ That’s a very few cases, but you see a kind of the power differential occur.

Fear of encountering police and deportation in some scenarios was thus used as a form of abuse among women who had experienced IPV. Although the power dynamics in the relationship changed, fear of police still served as a weapon of violence. Furthermore, fear of encountering police not only impacted frustrations leading to violence, not reporting violence, or putting up with abusers, but also played a role in seeking services for IPV. Just as I described in the
previous chapter with health services, fear of encountering immigration authorities shaped some undocumented immigrants’ willingness to seek IPV services.

**Not Seeking IPV Services**

As I described in the previous chapter, some undocumented immigrants changed how they received health services as a result of immigrant policing. Avoiding certain types of care extended into services for IPV or seeking new methods of receiving services, as Sofia described. “We see it in terms of people seeking services over the phone now because they’re afraid to drive.” Similarly, Marta explained that she ended one of her IPV support groups because participants were too fearful to drive to the meetings. “In 2008, I had a support group, and it was the beginning of when Gwinnett County was applying for the 287(g). Even though the law wasn’t there yet, [police were stopping a lot of immigrants] and a lot of my clients stopped going to the support group until I just had one or two. So I had to stop the groups because nobody was coming.” Before stopping the support groups Marta called all of the group members to ask if they were going to continue coming to the group. “When I called they would all ‘you know what Ms. Marta, I’m afraid to drive over there because my sister-in-law got pulled over and everybody in the car had to show their ID, so I’m not coming anymore because I’m afraid we’ll get pulled over.’ And so the groups stopped because they were too afraid to drive.” Elaborating on the challenges in getting to group meetings, Lori explained that immigrant policing and unreliable mass transportation system made it difficult to receive IPV services.

You’re just trying to live the life that you used to and it became a lot more difficult having to walk everywhere. I had this woman coming to my support group for domestic violence in Gwinnett--poor lady. She was dragging two kids, with a stroller, and the bus there only passed every two hours or so, so she would be late like an hour, and it was either that or be super early an hour, and she
would always arrive at the end of my group dragging these children and everything, and she was really tired. She tried so hard because she wanted to be in the support group. She was a nervous wreck and she really wanted the service and just by seeing her I would get so exhausted because I know how long the ride was, and carrying three children and everything. That’s like a whole day affair just to come to the support group. So people were definitely not taking the risk to drive because they were afraid to get stopped. This one woman who got stopped while she was driving to us got arrested and her children were there in the car and it was a mess. I think women were really afraid of being separated from their children. The husband could go and maybe come back, but women were not taking the risk of driving.

As some of these stories suggest, just as police presence has hindered seeking IPV services, police activity has also undermined community trust and directly impacted IPV and family violence for some families.

**Police Undermining Community Trust**

In addition to impacting family violence by having an increased police presence that threatens families’ economic stability, immigrant policing further plays a role in family violence as it undermines community trust among Latinos. Some police officers recognized how immigrant policing damaged the relationship between law enforcement and Latino communities, as Sofia claimed.

Some police officers are talking to us about this. One guy said ‘we spent so long building a relationship with the Latino community and telling them that they could trust us and telling them that we were here to help, and then this kind of law comes into play and then all of the sudden we’re responsible for something we didn’t sign up to do.’ We don’t think about the cops complaining about it, but at the same time what they want to concentrate on is getting the bad guys not getting the people who may or may not have documents. So now all the work that they did to gain the trust of the Latino community is kind of being thrown out the window, so even some cops are getting frustrated about this and saying ‘we understand something has to be done, but this is not the way to address the problem.’

245
Sofia’s comments about police relationships with Latino communities was echoed by other immigrant rights organizations and police officers I met through the Cobb United for Change Coalition (CUCC) by participating in their police watch objective. Experiences with officers who are interested in maintaining trust with Latino communities and stories of racial profiling and police misconduct demonstrate how law enforcement is not a monolithic agency and has individual agents acting on and interpreting set objectives. Contrasting Sofia’s comments about police, Lori noted that relationships among Latinos and police officers were damaged directly by how some officers responded to IPV situations. Lori explained that in some situations police do not appropriately address IPV when called, which further decreases some immigrants’ willingness to seek assistance for violence.

Sometimes the police will get called and I have this one client who called the police and it was Christmas. The police came and put [the abuser] in the car and they took him around the block and they talked to him and told him ‘you know it’s Christmas. Why are you fighting with your wife?’ And they turned around and took him back home. And they didn’t even make a final report. So she called the police and maybe she’s in more danger now, and there’s no record of it.

Moreover, police relationships with those reporting IPV are hindered by some officers not appropriately responding to language differences. As Marta explained, some law enforcement agency telephone operators will not use the language line translation service when speaking to non-English speaking callers.

Sometimes they call the police and the police don’t want to use the language line—a lot of times that happens. So if they call one time and they say they don’t speak English then the police will say ‘don’t call anymore.’ A client will say ‘I called twice and I can’t communicate with the police, and he spoke to them and I don’t
know what he said and they didn’t do anything, and they let him in
the house and he is more angry now.’ They are supposed to use the
language line but they don’t use it because it’s expensive. I know
they have the funds and I know they have an account, but they
don’t use it.

As Marta and Lori’s comments demonstrate, inadequately responding to calls regarding
IPV and failing to use the language line when speaking to non-English speakers further damage
relationships between Latino immigrants and police officers while contributing to family
violence. Police activity therefore not only contributes to IPV through enforcement actions, but
also through inaction to fully investigate IPV or attempt to communicate with non-English
speaking callers. This is especially important to consider as research examining Latino
immigrants’ relationship with police is tied to a variety of factors (Giles et al. 2012; Menjivar
and Bejarano 2004), and some research has attempted to specifically examine determinants of
attitudes towards police (Correia 2010). IPV responses and responses to crime, generally, may
therefore be an important local consideration when attempting to understand determinants of
police relationships with Latino specific Latino communities.

**Interacting with the Legal System and Legal Options for IPV**

In addition to occasional problems with police when reporting IPV, navigating the US
legal system can be challenging for undocumented immigrants going through IPV and family
law cases. Although organizations like PDV assist immigrants with legal concerns related to IPV,
including aiding in applying for U visas, the organizations and clients face several procedural
barriers. The U visa process requires petitioners to submit a form I-918, relevant credible
evidence, a signed statement of victimization, and certification of assistance in investigating or
prosecuting a crime from a law enforcement official (Abrams 2009). As scholarship on U visas
has identified, using law enforcement officers as “gatekeepers to the U visa relief” is problematic
because it is inconsistent and relies on discretion of the signing official (Abrams 2009: 376).

Officer discretion was particularly frustrating for Marta, who navigated legal systems with IPV clients at the organization where she worked and tried to get certifications of assistance signed.

At first it was really difficult [to complete certifications] because some officers, when they signed the certification they felt like they were actually the ones giving papers to the person, and they would say ‘I don’t know this person, they could be a criminal and why would I be signing a document that is basically going to give them papers?’ And so there needs to be a lot of education, you are actually not the one making the decision, you’re just saying that this person reported the crime. In the end it’s up to them to sign it.

As scholarship on U visas and Marta’s experiences demonstrate, law enforcement officers act as key figures for U visa applications and may restrict applicants from completing their submissions. Challenges in getting certifications of assistance signed are not the only difficulties undocumented immigrants experiencing IPV have in navigating the US legal system.

In addition to challenges with getting U visa paperwork signed, Lori highlighted how not understanding immigrants’ family relationships can play a role in legal outcomes related to family affairs. One of Lori’s clients referred to her partner as her husband, for example, but the marriage was not legally recognized since they had not filed proper paperwork. This had resounding implications on Lori’s client, whose partner was abusive. “This one woman had three children and had been very isolated. She didn’t drive but he did, and he would leave home and take the car. She barely had any contact with her neighbors. Finally I think one day after he beat her she escaped and came to our safe house.” Lori became involved in the case once this client was at the safety house and a custody battle between her client and the partner ensued. “After they had separated, he married an American woman immediately, and so now it seemed like at least through the eyes of the court, he would be getting his papers soon or something and
she wouldn’t.” This damaged the case for Lori’s client to maintain custody of her children. Furthermore, her client’s credibility was eroded by referring to her partner as her husband.

“[In court] they called her a liar because she referred to him as her husband and in the Latino culture here if you’re living together with someone and you have children together and you’re not necessarily legally married, you call them ‘my husband.’” Ultimately immigration authorities came to court and played a role in determining custody. “Long story short,” Lori summarized, “her children were taken away from her and she was given a reunification plan in which she was supposed to take English classes, take her GED, go to counseling, get a psych evaluation and get papers. So if she wasn’t able to meet those requirements then she wouldn’t get her children back.” Commenting on these tasks, Lori explained her client felt the burdens were almost insurmountable. “I think it was really difficult, really, really difficult. After a while she just felt defeated.”

Like Lori’s client, during my time in Atlanta numerous immigrants referred to each other as husband or wife and clarified that they did not have a legally recognized marriage. By referring to her husband, the woman that Lori described spoke about the man she thought of as a husband, but this term ultimately impeached her credibility and may have impacted the court’s decision regarding her children. This scenario further demonstrates how family-related impacts of immigration laws and IPV combine in the legal system, and may ultimately result in one undocumented women losing her children, as many immigrants I met in Atlanta feared would happen to them.

Discussion

Findings highlighted in this chapter point to the very different but related family impacts of immigrant policing. Experiences like Verónica’s and stories from Anita and Mari point to how
immigrant policing can result in family separation how fears of potential family separation manifest in producing contingency plans in the event of parental deportation. Immigrant policing therefore plays a role in dividing immigrant families and instilling fear of family division in non-divided families. Furthermore, immigrant policing also plays a role in exacerbating existing IPV or contributing to the context in which IPV develops.

Although literature on the family-related impacts of immigrant policing describes what occurs to children after entering “exile” or “orphan” status (Barajas et al. 2008; Bhabha 2004; Chaudry et al. 2010; Leventhal and Brooks-Gunn 2004; Zayas and Bradlee 2014), research paying specific attention to how families and children understand and respond to situations resulting in “exile” or “orphan” status is needed. Findings from service providers in this chapter demonstrate how some children may internalize fear, shame, and guilt in response to family separation, demonstrating how children are not only affected by deportation outcomes, but also by governing processes such as immigrant policing. Rather than focusing on outcomes, this research therefore documents the process surrounding deportation and threats of family separation.

The potential for undocumented immigrant parents to be deported demonstrates the unique relationship between the state and children of undocumented parents as both “paternal protector and punishing regulator” (Heidbrink 2014: 3). Just as undocumented unaccompanied minors intimately feel the dual role of the state as they are temporarily cared for but eventually deported, citizen children of undocumented immigrants can experience the paternalistic and punitive capabilities of the state as their parents may be removed from the country and they can enter state custody. These actions demonstrate how the state emphasizes its paternalistic role to ostensibly care for citizen children, but parental removal further points to how the state can
manage citizenship. Parents are removed from the US because of alleged criminal activity demonstrated through their legal status, and citizen children may stay with legal resident caregivers or become state dependents. Removed parents thus enter a relationship with the state where they are criminally othered and deemed fit for deportation and termination of parental rights, all in an effort where the state determines citizenship legitimacy and exerts a form of punishment.

In addition to contributing to literature on family impacts of immigrant policing, findings from this chapter also contribute to literature on IPV among undocumented Latino immigrants whose IPV experiences intersect with numerous social and health-related challenges to seeking services (Parson et al. 2014; Salcido and Adelman 2004). Whereas some research identifies the role of fear in reporting IPV (Raj et al. 2004) and ethnographic accounts of IPV point to broader social contexts connected to violence (Hall 2000), this research specifically situates IPV within the social context of fear resulting from sets of polices and police practices. Findings in this chapter point to the way in which immigrant policing directly contributes to exacerbating existing violence or contributes to the potential for new violent events. Emphasizing the social context of IPV among undocumented immigrants rather than treating fear of police as a determinant for reporting violence allows for deeper examination of how immigrant policing magnifies risks for IPV. Furthermore, focusing on immigrant policing and the relationship to IPV allows for examining how IPV is similar to other family impacts, such as stress over potential family separation, and how these impacts share a common root contributing to internal forms of family destabilization.
Internal Destabilizing and Reproducing External Violence within Families

Assessing the different but related types of family impacts of immigrant policing ultimately allows for considering how immigrant policing as a type of social violence is reproduced within family settings. Interviews and participant observation experiences reveal how localized immigration enforcement may result in family separation and increase existing or potential IPV, demonstrating the way in which social violence of policing that destabilizes immigrants’ communities outside of their homes becomes reproduced in family settings and destabilizes social networks internally. Immigrant policing therefore cannot only disaggregate immigrant communities through an objective of fear-based enforcement operating outside of homes, but can also disaggregate and dismantle intimate home spaces from within, sometimes through family separation and threats of deportation, and occasionally through more corporeal forms of violence, as demonstrated by accounts of IPV.

Just as family separation and IPV are ways of destabilizing immigrant families, so too are various forms of citizenship that operate in mixed-status households. Differential forms of citizenship may threaten family stability and some household members are able to receive services others are not (Castañeda and Melo 2014; Heyman et al. 2009c). These factors highlight a need for additional research examining the external conditions that shape immigrant family cohesion and internal stability.

Resistance Narratives and the Family-Citizen

Lastly, findings from this chapter suggest how resistance narratives focusing on family impacts of policing emphasize an exclusive type of family-based citizenship. In many of the GLAHR appeals for “stopping family separation,” stories of parents being deported and leaving
their children provide emotional appeals intended to inspire political action. These stories, however, assert a notion of family-based citizenship that merit critique.

Although family narratives are powerful appeals for ending immigration policies that disrupt family ties, some of the narratives in Atlanta were a form of asserting national-based citizenship that underscores undocumented immigrants' deservingness to remain in the country on the basis of being family-citizens. Family narratives for stopping immigrant policing are rooted in notions of a deserving US citizen-child worthy of having parent caregivers. These narratives are distinctly different than the narratives of “unaccompanied alien children” who arrive to the US without a parent or guardian and are viewed as a political problem requiring solving that may include deportation (Heidbrink 2014: 2). Separating the “unaccompanied alien child” message from the family-related resistance message embraced by GLAHR and others, is the way in which parents are presumably indicted for their border-related transgressions that their citizen children had no part in, unlike the children “aliens.” At the core of these family narratives in some resistance message are thus ideas of privileging US citizenship rather than focusing on the violence of policing. Although the violence of policing is present in the family narrative, the reprehensibility of policing in the family narrative is due to the fact that it impacts US citizen children.

Moreover, family narratives in resistance efforts do not always reflect the family situations of immigrants present in the US. Verónica, for example, has three children from a father now in Mexico who may have other children with other women, and Verónica does not have any children with her live-in boyfriend who provides financial support for the entire household. Family narratives focusing on citizen children ignore how immigrant policing has lent itself to complicating family arrangements through increasing police intensity in assessing
immigration status that limits easy transnational movement and therefore hinders maintaining transnational family arrangements. Similarly, definitions of family that point to parent and child separation narrowly define families in a way that excludes partners without children, including gay and lesbian families. These families are greatly underrepresented in literature on family impacts of immigration policies and deportation, and were largely absent in family-related impacts resistance narratives.

Figure 19: Holding family reunification signs outside a legislator's office during the "Keeping Families Together" bus tour.

Conclusion

Building upon previous descriptions of immigrant policing as a form of violence, this chapter demonstrates how external violence through policing permeates social boundaries and enters family relationships to form a type of internal violence that disaggregates family relationships. Families such as the one Verónica formed with her three children and their father,
become fractured\textsuperscript{47} through policing tactics leading to deportation and increase fears of potential family separation leading families to develop contingency plans in the event of parental deportation, as demonstrated by my interactions with Mari. Similarly, immigrant policing disrupts family lives by exacerbating existing IPV or leading to new IPV incidents. While family-related impacts are used in resistance narratives, these narratives pay some attention to the social violence of immigrant policing that leads to family separation but employ a notion of a deserving child-citizen and exclude specific types of families. Moreover, no evidence suggests how effective family-related narratives are in challenging immigration policies, suggesting alternative narratives may be needed.

Existing policies to assist immigrant families may also be ineffective, however. For example, forms of relief for undocumented immigrants provided through U visas are rooted in the criminal justice system and are focused on prosecution and compliance in investigations. As such, U visas are not a meaningful form of relief as they place immigrants into the system of law enforcement they fear and distrust (Davis 2004), and a low number of U visas are available to undocumented immigrants. In this respect, U visas, which are touted as a means to grant victimized undocumented immigrants reprieve from the deportation regime, are means with which to ensure undocumented immigrants are involved in criminal justice systems and put into view for enforcement officials. Much like the informal providers described in the previous chapters that purportedly provide care but may do more harm than good, U visas may provide an appearance of deportation relief that does not actually exist. Few forms of legal relief and an

\textsuperscript{47} This is not to undermine Veronica’s new family construction with her boyfriend or other ways that families can become altered by divorce, death, extramarital sex, or a variety of arrangements. In noting this, I merely intend to point out that immigrant policing and deportation were the cause of the change in the arrangement and the family change did not occur based on expressed desires or actions of those involved in the change.
immigration regime that can destabilize communities and families points to the emergent need for challenging localized immigrant policing that has long-term impacts on immigrant populations living in the US.

In the next chapter, I shift analytical focus from undocumented immigrants to health providers, demonstrating how immigrant policing pervades numerous spaces and impacts providers. Just as undocumented immigrants resist forms of immigrant policing, so do providers, drawing from medical knowledge to resist forms of professional control.
CHAPTER EIGHT

“THAT SOMEBODY WOULD HAVE THE BALLS TO PUT THAT IN LEGISLATION—THAT’S DISTURBING:”

HEALTH PROVIDERS’ RESPONSES TO HB 87 AND IMMIGRANT POLICING

Introduction

Walking into The Healing Grace of God (HGG)\textsuperscript{48} clinic, I was struck by the size and newness of the facility. Faith-based organizations I worked with in previous research endeavors used facilities that were mobile or fixed and not nearly as nice or new as this Atlanta clinic. As I waited at the front desk to speak to someone behind a sliding glass window I peered around the bright, well-lit room. GLAHRiadores and members of the Hispanic Health Coalition suggested that I reach out to HGG, claiming it was a place numerous undocumented Latino immigrants went for care. In scanning the waiting room as I entered the building, I heard patients speaking Spanish and saw African-American men and women filling out forms.

“Sign in, please,” a woman said to me without looking up from a clipboard she was reviewing.

“I’m actually not here for an appointment—I have a meeting with Dr. Taylor,” I responded.

\textsuperscript{48} This name is a pseudonym for a faith-based clinic operating in Atlanta that sees immigrant patients.
“For what?” the woman asked, looking up at me, her gaze passing over the top of her glasses that were precariously perched on the end of her nose.

“I’m interviewing him about health care for Latino immigrants in Atlanta. Is this the right place? It was the address he sent me.”

“Hang on a sec. Sign in and I’ll go ahead and find him.” The staff member then turned away from the desk and began asking her colleague to page Dr. Taylor. I followed instructions and began filling out a patient arrival sheet. “When you’re done signing in just have a seat and we’ll call you.”

As I looked for a seat in the half-full waiting room the size of a university classroom that can accommodate 50 students, I noticed that nearly every vacant seat had a Bible on it. Taking my place in an empty seat, my eyes scanned the walls, which were adorned with crosses and images of angels. It was clear to me that HGG had very accurately characterized itself as a faith-based clinic. I reached into my bag to remove a notebook to begin writing notes when a nurse summoned me.

“Mr. Kline? You can come on back.” I was escorted into Dr. Taylor’s private office where I was told to wait at a round conference table near the door. The table was positioned in a corner, abutting walls covered in running medals, triathlon awards, race photos, and framed marathon participant stickers. After waiting for several minutes, Dr. Taylor, the founder of HGG, entered the room carrying a plate with his lunch.

“Sorry to keep you waiting. So you’re wanting to talk about illegal immigrants and health care?” Dr. Taylor said, taking a seat and almost immediately cutting into his perfectly round, gray vegetarian hamburger patty. Caught off guard by his curtness, I attempted to explain my dissertation project and ask about HGG, which Dr. Taylor opened in the mid-1990s. As our
conversation turned to focusing on undocumented immigrants and HB 87, specifically, Dr. Taylor shared some of his frustrations with the law.

“We have a ton of illegal patients but we don’t identify them, and I’ll tell you why we don’t. It has nothing to do with a view of public policy—it has nothing to do with that. My view is that first of all it’s the government’s job to police the borders, it is not my job. That’s why I pay taxes…it’s not my job to police the borders!” After explaining how he viewed the current immigration situation as a result of federal inaction, corporations wanting cheap labor, and immigrants wanting to improve their economic circumstances, Dr. Taylor explained that he would provide care for patients regardless of their immigration status. “Our job is once the person is here and they want healthcare, to provide it. For example,” Dr. Taylor continued with aggressive fervor, “a mother with a little baby who’s six months old and has a 103-degree fever appears at my doorstep. Well that little child doesn’t have any control over his situation. He didn’t ask to be where he is right now; he didn’t ask to be sick!”

Using the child with a 103-degree fever as an example, Dr. Taylor continued to explain why he felt it was important to provide care to any patient regardless of immigration status. “We feel like it’s our moral obligation to do what we can to try to take care of that child within our scope and ability.” Beyond simply caring for a child who “didn’t choose to be sick,” Dr. Taylor further explained his motivations as a physician being rooted in his faith.

We feel like we should be doing this because of the idea of service. Most of these people, directly or indirectly, are serving me, so we’re serving them back. And you could say that’s biblical, well it is biblical, moral and biblical. Those are people who are cleaning my yard; they’re blowing leaves off my yard where I live, or they put a roof on the house of the people who lost it because of the tornadoes last week, or they’re picking the vegetables that appear at my grocery store that I’m eating. So this is our way of serving
them and again it goes back to that moral of that person who appears at our doorstep and is sick and needs help. So we feel like that’s our job—not policing the border.

Throughout our interview Dr. Taylor attempted to anticipate my questions and reiterated his disinterest in documenting patients’ immigration status. “Now you are probably going to ask the question there do we document people, and no we don’t. Again because it’s my philosophy that it’s not my job, it’s the government’s job to police the borders, it is not my job!! So I’m not going to do that.” Dr. Taylor then clarified that he assesses his employees’ immigration status, but not his patients’. “We hire people who are here and legally able to work in this country, but as far as who we treat, they choose to come here and they need us and their baby needs care, we take care of them.”

Continuing to express his concerns with how immigrant policing and laws like HB 87 impacted providers and his organization, Dr. Taylor argued that the time it would take to assess a patient’s immigration status was an inappropriate use of his time.

This stuff about not treating people because they’re illegal—the thing about being a physician or dentist or whoever, is that our education and skill set is really to take care of a person. If we all of the sudden have to start trying to assess whether someone’s here legally or not, you’re robbing me of doing what I do well and therefore you’re robbing time from me, and therefore that’s a patient I can’t see because I’m taking the time to do something else! If you think about time, resources, and skill sets, and things like that, it’s a bad use of skill sets for me to be doing that. And then you can say ‘okay well you can ask your staff to do that.’ Well if I’m asking my staff to do that, again I’m asking somebody to give their time, if everybody’s being checked who comes through that door, we have to hire a whole other person to do that. You have to hire that whole other person and I have to pay that person, and again that’s money that I can use for some other purpose, such as hiring another doctor. So again, that would be fewer patients that I would be able to see.

Dr. Taylor’s assertions of how immigrant policing and HB 87, in particular, impinged
upon his professional practice mirror interviews from other providers. Several interviewees expressed a sense of outrage or inappropriateness with legislation interfering with their professional practice in a way that prohibited them from providing certain types of care to undocumented patients. Although Dr. Taylor’s motivations for treating undocumented immigrants was partly informed by a religious perspective not shared by other providers I interviewed, his sense of outrage that legislators would impose upon his professional practice was a common theme in several interviews.

This chapter focuses on providers’ responses to immigrant policing and immigration laws that target both undocumented immigrants and health providers, such as HB 87. In addition to focusing on how providers viewed immigrant policing, I also describe how some providers’ organizations had to adopt changes in direct response to immigrant policing.

**Why Health Providers?**

As part of the multi-sited design of this dissertation, I interviewed health providers to understand the reach of biopolitical aims articulated through immigrant policing initiatives such as HB 87. HB 87 was of particular importance for conducting interviews with providers since it affected health providers in two ways: first, by restricting healthcare workers’ ability to provide care to undocumented immigrants, and second, by creating new requirements for providers to renew their professional licenses. When HB 87 passed, section seven of the law expanded definitions of “harboring an illegal alien” to include “any conduct that tends to substantially help an illegal alien to remain in the United States in violation of federal law,” with some exclusions. This provision alarmingly implicated all persons, including medical providers, with committing a crime if providing publicly financed services to undocumented immigrants. Despite the emphasis on publicly financed services, HB 87 not only affected providers working in public health
departments and in public hospitals, but arguably every Georgia hospital receiving some amount of state funding. Although the 11th Circuit Court of appeals struck this provision while I was doing fieldwork, HB 87 was nevertheless signed into law with the language restricting providers’ ability to care for undocumented immigrants in non-emergency situations. Additionally, HB 87 created new hurdles for providers in renewing their professional licenses. The law requires all licensed professionals, including health providers, to submit proof of their legal status when renewing their license. The implications of HB 87 on health providers thus deserve ethnographic attention since the law demonstrates a how regimes of immigration enforcement can permeate numerous social levels, including professional arenas related to health care.

Moreover, research with health providers directly responds to recent critiques of medical anthropologists focusing solely on “the suffering subject” (Robbins 2013) and acknowledges calls for anthropologists to “study up” (Nader 1972) in ethnographic work. Conducting research with providers and focusing on undocumented immigrants’ health, specifically, contributes to literature examining health providers’ understandings of immigrants’ desiringness to health services, views of medical citizenship (Goldade 2009), and motivations for providing care to marginalized populations (Castañeda 2011).

Lastly, examining how health providers may be used in immigration enforcement efforts can point to shifting forms of “audit cultures,” whose focus on accountability merges notions of economic efficiency and moral reasoning to shape ideas of best practices (Strathern 2000). Medical professionals are entwined in numerous types of audit cultures that assess behaviors and cost efficiency, and research examining how policy impacts providers must consider how policies may point to changing types of audit cultures and emerging notions of accountability. When HB 87 passed, provisions that implicated providers in policing efforts extended audits of
medical professions to include requirements to enforce immigration laws. This chapter underscores how providers resist audit cultures even if their profession is replete with them.

**Research on Health Providers and Policy**

Anthropologists researching providers’ relationships with power regimes have argued that providers are involved in systems of authority and power, and that in some circumstances health providers’ anxieties or discomfort with specific policies can call into question state power generally (Ashforth 2004; Bazylevych 2011; Koch 2006). Similarly, research on how policy changes can impact providers suggests that health care workers are entangled in discourses and ideologies of power that drive specific policies, including applying neoliberal ideologies to health care in order to advance market-based medicine and shape notions of accountability that consider medical need and economics (Boehm 2005; Horton 2001; Lamphere 2005; Rylko-Bauer and Farmer 2002). Additionally, research on policies affecting providers has documented how legislation can change patient-provider relationships and serve as disciplinary techniques for both groups (Willging et al. 2008). Furthermore, policies allow providers to deny specific types of care, such as abortion services, allowing for greater restrictions and systematic reductions in types of services provided (Mishtal 2009).

Accordingly, this chapter examines the way providers were implicated in immigrant policing efforts and how immigration laws affected providers. This chapter further adds new insights to literature on current or future providers’ understandings and responses to policy change (Castañeda et al. 2011; Lamphere 2005) by exploring potentially concealed impacts on providers through what is chiefly viewed as immigration policy. Focusing on immigration allows for a wider understanding of how policy and legislation are used to shape health providers’ professional practice, especially for politically contentious topics such as immigration. Although
policies driven by political ideologies may prohibit specific provider actions, such as recent abortion policies limiting where and when providers can do abortions (Grossman et al. 2014; Joyce 2011), restrictive policies targeting providers have not necessarily determined what patients providers can or cannot treat. Legislation such as HB 87 prohibited providers from providing non-emergency services to an entire group of patients—undocumented immigrants, demonstrating a larger than usual encroachment on providers’ professional practice. Moreover, legislation like HB 87 reinforces notions of medical undeservingness, and research on how policy affects immigrants’ health must pay specific attention to providers’ perceptions about policies asserting medical undeservingness and denying formal types of medical citizenship.

Despite the importance and necessity of research with providers in understanding health-related impacts of immigration laws, there are numerous challenges in reaching provider populations. During my time in Atlanta, I contacted all major hospitals and public health departments in the area to speak to providers and hospital administrators. Two major hospitals refused to allow interviews with providers and administrators, and two hospitals and one department of public health failed to respond to repeated requests. These institutional barriers were especially frustrating given some providers’ individual willingness to speak with me, but they were unable to secure institutional approval to participate in the research. Despite challenges in reaching some providers I was able to successfully interview 18 health providers who shared their experiences and perspectives regarding immigrant policing.

---

49 Although insurance regimes may arguably work this way and prohibit providers from seeing uninsured or indigent patients, no policy explicitly criminalizes provider actions that result in indigent or uninsured patients receiving care.

50 Providers were recruited through publicly-available means, such as a hospital’s website listing their names and emails, and through snowball sampling, asking providers to refer me to their colleagues.
Findings from Interviews with Providers

Direct Impacts on Providers

As noted earlier, initial provisions of HB 87 criminalized providing publicly financed non-emergency health services to undocumented immigrants and required all licensed health providers (and any other professional with a regulated license, such as hairdressers and cosmetologists) to submit proof of legal status when renewing their professional license to the Georgia Secretary of State, as mentioned in Chapter 5. Although provisions related to assisting an undocumented immigrant were struck down by the 11th Circuit Court of Appeals ruling, the provision about license renewal remained intact. This provision resulted in large delays in license renewals and overwhelmed the Secretary of State office, which was given the task of verifying licensee’s legal status. The inability of the Secretary of State to keep up with license renewal demands resulted in The Georgia Composite Medical Board reporting that, at least at one point in time, 1,300 medical professionals lost their legal ability to practice (although the cumulative number of providers affected is not reported) (Burress 2012), and the Secretary of State placed holds on 3,500 nurses because they were unable to verify their legal status (Crawford 2013). The administrative hurdles in renewing licenses remained a concern for providers until SB 160 was signed into law with an effective date of July 1st, 2013. As one provider commented on his employer’s response to the licensing problem:

We got this email from HR and they were freaking out about us needing to renew our licenses immediately. Usually you just do it one or two weeks before it expires, but I guess that wasn’t working anymore because there were people who submitted the renewal and it didn’t go through in time, so they literally were working their shift and their license expired and they had to stop. So after that, everyone freaked out and they started making us renew our license months ahead of time.
Another provider, Dr. Manheim, commented on not knowing why new procedures were in place when he had to renew his license. “I got this email not too long ago where they were asking me for a copy of my passport. I’ve never had to do it before and I remember thinking that was odd. I thought it was strange at the time, but it sort of makes sense now that I think about it with this law.” Dr. Manheim is a dark-skinned immigrant who moved to the US with his family when he was a child. When he received the email about having to show his passport he initially assumed it was because of his ethnicity. “When I first got it I thought ‘is it because I’m Arab? Would they ask my boss to show a passport?’” Dr. Manheim continued to explain that for his hospital, changes in licensing requirements do not necessarily harm individual providers, but instead affect the entire institution. “For each provider individually it’s certainly not a big deal if you make a photocopy of your passport and turn it in. On an institutional level though, and at a hospital like this one, in particular, with so many doctors, it can create a lot of turmoil. A lot of this stuff is stupid, so what’s the point?”

Dr. Manheim recalled hearing something about licensing changes when HB 87 was discussed in the media but never paid much attention to the specifics. He, like many other providers I spoke to, considered HB 87 an unnecessary, if not upsetting, measure of oversight that impinged upon providers’ professional duties.

Providers’ Views of HB 87

Many providers I spoke to described provisions related to providers in HB 87 as unenforceable or an encroachment on professional responsibilities, echoing Dr. Taylor’s comments. One physician, Dr. West, who worked at the same hospital as Dr. Manheim, expressed outrage and incredulity about the legislature interfering with providers in a way he understood HB 87 did, saying, “that somebody would have the balls to put that in legislation—
that’s disturbing.” Dr. West continued to explain that he felt providers were underrepresented in politics, noting that the American Medical Association did little for medicine and only strived to benefit providers’ financial interests and work with insurance companies. He argued that the nature of the profession potentially limited providers’ involvement in political processes, which he saw as responsible for portions of laws like HB 87 that criminalized some forms of providing care to undocumented immigrants.

The problem with physicians—and I think it’s a generalization, but I think it’s why we are where we are in healthcare—is that we are so busy and overwhelmed with the care of medicine that politics and these other things…we don’t have time for it. You know, we’ve got patients to see and that’s really killed us because we don’t stand up and fight for things, and it’s not because we don’t care, it’s because we’ve got another patient in front of us. And I think that’s a sad reality and that’s why we’re pushed around by some of these crazy ass policies coming out of DC and our [state] administration. We essentially have no voice on the Hill.

Like Dr. West, Dr. Manheim expressed a sense of incredulousness for provisions in HB 87 that applied to providers. “Ultimately it obviously got thrown out [the provision about providing care], so I think that was certainly the right thing to do, but the fact that even sort of made it is kind of ridiculous and terrifying.”

To many providers like Dr. Manheim, HB 87 seemed impossible to enforce. “Honestly,” Dr. Manheim explained, “I think it would be one of those things that if they did actually prosecute someone for, first of all who would do that, and second of all, what would happen from a community perspective to say to people ‘this is really what happened: a doctor was arrested for taking care of a patient?’ Well that’s their job.” Similarly, another provider at a large Atlanta-area hospital, Dr. Pfeiffer, explained that he was under no professional obligation to refuse care to any patients, and that a legislative attempt to require him to do so was inappropriate. “I have to report potential harm or danger to self or others. It’s not appropriate to
Beyond viewing provisions in HB as unenforceable or encroaching on professional responsibilities, some providers I spoke to had responses informed by notions of humanitarianism, not unlike Dr. Taylor’s, but not guided by religious beliefs. One provider at a teaching hospital, for example, said, “I see a patient, students see a patient—I don’t care what their immigration status is, they are human beings. They have something that we can take care of and that is our job. Ours is not to judge, ours is not to inquire.” For some providers, perspectives on HB 87 and immigrant policing translated to direct notions of resisting complicity in biopolitical endeavors focused on undocumented immigrants.

**Resistance Responses to HB 87**

Some providers viewed provisions in HB 87 as only applying if the fee for service came from a governmental source. Although HB 87 criminalized providing publicly financed care to undocumented immigrants, providers like Dr. Taylor viewed this as literally having a government pay for the service rather than an organization receiving funds from a governmental source. As Dr. Taylor said, “if the government’s paying for it they can say it’s illegal, but they’re not paying for it. So if you’ve provided nonemergency services for someone and the government’s not paying for it, and the patient is paying for it, we have not violated the law.” Pointing to what he viewed as the absurd exclusion of emergency care, Dr. Taylor noted many undocumented immigrants use the emergency room as a source of primary care. “It depends on how you define an emergency because a lot of people use the emergency room,’” Dr. Taylor said in an exaggerated way, using air quotes, “for their primary care when in reality what they’re having is not a real ‘emergency’ but they still use the emergency room for their primary care, so what’s the emergency room supposed to do about that? Sometimes they have a hard time turning
people away—they’re there, and they’re sick.” As Dr. Taylor suggested, all of the emergency room physicians I spoke with mentioned they would not turn away patients even if they were not experiencing a medical emergency.

Commenting on emergency room providers generally, one ER physician, Dr. Drake, explained that he had no interest in determining a patient’s citizenship before providing care. “Particularly in the emergency department, and it probably gets us in trouble, but we tend to be pretty altruistic. We tend not to worry about somebody’s citizenship. In general we’re going to take care of everybody regardless of race, creed, color whatever the case may be. So things like the bill, and immigration, and checkpoints, we tend not to think about that at all quite honestly.”

Dr. Drake explained that although citizenship or legal status considerations do not impact how he provides care, it will impact how he recommends follow up care:

When we have to think about the follow-up plan, we do have to think about [legal status and ability to pay] a little bit at least because we have to understand what a patient can and cannot afford, we have to think about where we can send them, and those kinds of things....rarely do we ask about citizenship per se. Now we may ask where you live because if you live in Fulton or DeKalb County you qualify for a Grady card, the scaled card based upon your income and resources that determines how much you have to pay for your medication and for your visits or whatever. That is tied to your local residence, so that’s important.

Emergency care is specifically excluded from provisions in HB 87, and for providers like Dr. Drake, providing care through the emergency room was going to continue regardless of immigration laws, even if they extended to emergent care. “They’re not going to stop me from treating a patient that comes into our ER, regardless of citizenship, ability to pay, whatever.”

**Witch Hunts**

In explaining why they believed laws like HB 87 focused on immigrants but extended to
providers, some providers explained they felt the law was a “witch hunt” driven by racist attitudes. As one physician, Dr. Layne, who moved to Atlanta in 2006, explained, “I think it’s this knee-jerk conservatism, well, racism. I’ll call a spade a spade, I think that’s what it is—it’s not economic; that’s their very transparent cover up. Laws like these are racist.” Dr. Layne continued to explain that she saw historic similarities between how immigrants in Georgia were targeted by laws like HB 87 and other minority groups systemically lost their rights. “I know there’s ignorance behind it all. If you look at our history there have been some situations where this is how it starts, you know? It’s a witch hunt: people who look like this or are this religion or this orientation, you can’t help them. And then it becomes you can’t just help them, you have to get them. And that’s my fear: that we’re moving from just don’t harbor them in your home or help them to ‘get them!’” Echoing Dr. Layne, a nurse, Jane, expressed a similar but darker perspective:

To me it just harkens of pre-Nazi Germany. People are hurting, we have a bad economy, things aren’t going right for people, and it’s really easy to galvanize around some group of other. Right now our “other” is people south of the American border. Don’t worry about how we are screwing you over in all of these other ways, don’t look at that, look at the shiny thing over here. Blame these people for taking that tomato picking job that I’m sure you were going to take because I don’t know any Americans that pick produce other than high school kids picking watermelon in Florida in the summer.

Just as several other providers drew connections to immigration laws as racialized policies reminding them of Nazi-era politics and witch hunts, other providers adopted strong positions of resistance to laws like HB 87 because they considered them inappropriate ways of managing healthcare workers.
“I’d Be Happy to be Taken to Court:” Providers Resisting Audit Culture

In addition to identifying immigrant policing and laws as “witch hunts,” some providers actively adopted positions of resistance to the laws, including Dr. Hernandez, whose outrage over immigration laws was described in Chapter 6. “I don’t really pay any attention to whether it’s a law now or not a law,” Dr. Hernandez said. “I’m going to give care no matter what. If I could get fined or arrested because of that, that’s just how it’s going to be, but I think I speak for a lot of my colleagues, too.” In addition to Dr. Hernandez, one provider, Dr. Smith explained legislation would not change who he treated, and if anything, he and other providers would view such legislation as a challenge. “It wouldn’t affect what I did. It might criminalize what I do, but there’s a higher purpose, so I’d be happy to be taken to court. Let somebody try to throw me in jail for doing the right thing. I think in that sense it was almost a challenge. There was never a sense of panic over it,” Dr. Smith explained, noting that he and other physicians did not see HB 87 as something worth challenging through formal means. This did not necessarily translate to lacking a reaction to such a law, however, as one provider, Dr. Tobias, proved.

Having lived in Atlanta for nearly 30 years and considering himself politically engaged, Dr. Tobias noted that no piece of legislation would prevent him from seeing undocumented patients because he felt laws like HB 87 were written by Republican legislators representing the interests of conservative suburban residents. “These suburbs are just incredibly different from anything I was ever raised in. It’s this ‘I got stuff I don’t want you to have it and I’m afraid you’re going to get it’ mentality. ‘I struggled to get what I got,’ and all that kind of stuff. ‘We have traditions here,’ and that kind of thing. People in Atlanta who like things the way they are don’t want them to change. Echoing providers like Dr. Layne who viewed laws like HB 87 though a racial lens, Dr. Tobias explained the legislation in terms of Georgia’s suburban
expansion linked to its history of racial tension, explaining that suburban politicians used immigration laws to appeal to white voters concerned over the growing Latino population in Atlanta. “Stuff like this is just class warfare and racism…that’s always the subtext, it’s always racial, but those people are probably clever enough not to make it obvious.”

Although Dr. Tobias understood how racism could drive anti-immigrant policies he explained that he claimed not understand how economic arguments were considered persuasive. “The economic boost immigrants provide is incalculable. They’ve built every structure in Atlanta in the last 50 years. Those buildings would not be there if it wasn’t for that cheap labor, and how can you not understand that? That’s the part that I don’t get. That’s who mows your yard, for God’s sake!” Because of what he viewed as policies intended to protect interests of suburban residents, Dr. Tobias explained that he gave no attention to laws like HB 87 that limited his professional practice because of what he viewed as racist sentiments. “I see plenty of people who are undocumented, for sure…I think people in Atlanta realize those guys [legislators who co-wrote HB 87] from the suburbs are nuts.”

Confusion and Fear

Despite some providers expressing resistance and opposition to provisions in HB 87 that would restrict to whom they offered care, other interviewees explained that there was a sense of confusion and fear among providers. One community health advocate, Marco, who works for a large, private hospital, explained that many providers and community health workers at his hospital are unsure about whether proving care or organizing health promotion events is legal. “There’s still a big ‘don’t ask, don’t tell’ part of it, and people are a lot more guarded. The providers have this idea that they know they’re doing the right thing because they’re treating somebody that needs it, but they wonder if they can get in trouble for it.’ Marco continued to
explain, “nobody knows what’s legal and what’s not. We don’t know if we’re doing something we can get arrested for or not.”

Providers’ uncertainty about the legality of providing care to undocumented patients resulted in an advocacy group of the Hispanic Health Coalition of Georgia (HHCGA) to find information regarding immigration laws, explain how they impact providers, and distribute the information to members, some of whom are providers, board directors, or staff at Atlanta’s major hospitals. Because of my involvement with the HHCGA and the organization leaders’ knowledge of my dissertation, I was asked to take on this project along with an Emory master of public health (MPH) student. The result of our collaboration was a list of immigration laws with an explanation of how they impacted immigrants, potential impacts to providers, and long-term impacts on both providers and immigrants. The list of laws provided a summary of how immigration laws in Georgia may make some immigrants more fearful of seeking care but providers are not legally obligated to report undocumented immigrants to any authorities. With this list, the HHCGA cancer committee developed potential action plans to disseminate information to promotoras, providers, and organizations that provide cancer screening services or provide low-cost or subsidized care in order to combat potential fears in seeking services. This effort never materialized in any serious change, however, as the HHCGA experienced a complete turnover in staff and leadership that did not keep existing efforts put in place by previous leaders.

**Changing How Services Are Offered**

In addition to providers’ resisting or being uncertain about how HB 87 impacted them, some providers discussed how HB 87 changed the way undocumented immigrants received health services and how providers made services available. Dr. Green, a provider who living in
Atlanta since the 1990s, for example, noted that smaller, rationalized ways of reducing care made the results of decreasing services and increasing poor health outcomes more acceptable among the public. “There’s no watershed moment, so you don’t go from offering something to not offering anything. There’s very rarely a dramatic moment like that where you can say ‘that death was due to this [denying undocumented immigrants care]!’ It’s a death by a thousand little cuts. It’s hard to really document or show the effect of something like this.” For Dr. Green, the “death by a thousand little cuts” mirrors interior enforcement rhetoric where life became so challenging for immigrants that they chose to immigrate. From Dr. Green’s explanation, restrictions in types of care that can be provided is one of thousand cuts that may encourage “self-deportation.” Furthermore, several providers explained that difficulties in seeking care led undocumented patients to seek alternative forms of care, including the informal providers described in Chapter 6. In addition to understanding how immigrants may change seeking services, some providers described how they changed offering services as a result of immigration laws like HB 87 and broader forms of immigrant policing such as checkpoints.

Extending conversations to forms of immigrant policing other than HB 87, providers spoke about responses to checkpoints and interior enforcement of immigration laws. One provider, Dr. Arias, who runs a non-profit organization that provides mental health services to undocumented Latinos, explained that his clinic has been directly impacted by immigrant policing. “The number one reason for people not showing up for their appointments here is that they’re afraid to drive because they’re afraid they’re to going to be pulled over. Before all these immigration laws, we had a very low no-show rate.” One of the counselors at Dr. Arias’s organization added to this, explaining that no show rates increase during times when police may be more active, saying “During the summertime there are just a lot more cops out there checking
for speeding and when people realize what’s going on, one person tells another there’s a cop on [interstate] 85, or there’s a cop outside and people stay home. We have this no-show rate that’s extremely high during the summertime,” the counselor added. “When we ask why, they will tell us ‘well you know cops are everywhere, so we can’t leave the house, we’re going to get pulled over.’” Continuing to explain how patients were affected by immigration laws, Dr. Arias noted that all family members, regardless of documentation status, felt the impacts of immigrant policing.

We hear the stories that police have parked cars outside of the church, or the police have parked cars outside of school, so people don’t want to drive. Laws like HB 87 and SB 529 limit access because they required clinics and services to verify lawful presence. So couple of things we discovered: not only is the undocumented person unable to now go seek services, but we’re finding that they’re living in a mixed household with mixed levels of documentation status or lawful presence, and the ones that have documentation will also avoid going to the doctor. The reason we’re seeing this is that people don’t want to do anything that will draw attention to themselves and get a question about who lives with you, and they don’t put their family members in jeopardy.

As we sat in his office, painted in calming colors with a fountain running in the background, I asked Dr. Arias how his clinic responded to the increasing number of patients failing to come in for appointments. “It was a rude awakening,” he responded. “We had to implement business policies we never had to implement before, which are more consistent with physical and general practitioners than mental health practitioners, and specifically I’m talking about overbooking.” Rather than filling one appointment with one client, Dr. Arias explained that now more than one client would be booked for the same appointment.

You know when you go to your primary care physician you know that there are six people for that hour or four people for 11:15 because there are four rooms and they’re counting on somebody
not showing up. Well our business is a little different. Our appointment is an hour and if you don’t show up then I’m sucking wind for an hour and I have to pay a counselor and will have no money for that hour. So we ask for five appointments a day for our counselors, and at least some time for some supervision and note writing. So we started making appointments for seven or eight people just so that we can net five. That’s a business practice we never had to do before.

In addition to overbooking for appointments, Dr. Arias explained he also had to change services offered for children and train staff in a new billing procedure as a result of HB 87 changes. “Because of these policies we changed how we’re able to serve children. If a kid didn’t have Medicaid or if the kid didn’t have a CMO [care management organization51], we could bill our grant funding,” Dr. Arias explained. “The policies that took place at the state level have required that now before we access grant funding we have to find out why this child is not in Medicaid or CMO and we need to do everything in our power to get them signed up for Medicaid or a CMO.” This change resulted in Dr. Arias needing to train staff in enrollment procedures. “We had to train our intake staff to help family sign up for Medicaid, whereas we didn’t have to do that before.” Ultimately this process delays treatment for child patients, Dr. Arias noted. “Now we can’t begin services for 30 days so we have to be putting patients on hold while we try to enroll people in Medicaid. And the reasons why they’re not in Medicaid or CMO are several. There may be some confusion, the family had a bad experience, or they never did the paperwork because they didn’t know or they were afraid, whatever.”

Dr. Arias further explained that some parents feared bringing children to his organization’s programs, and as a result he purchased a small bus to pick up children from schools and take them in for services. Services include counseling and mental health evaluations,

51 Care management organizations are generally referred to as Managed Care Organizations, or MCOs.
but the organization’s primary focus on youth is preventing alcohol and drug abuse among through an afterschool clubhouse program with homework assistance, games, activities, and educational programs. The director of preventive services for children at Dr. Arias’s organization, Carla, explained that the buses were a direct response to parents fearing driving. “We have to provide them transportation because many of the parents are working and they have a big fear of driving, especially two years ago when the law changed and they were checking for licenses and they were doing stops, a lot of people stopped driving. They just completely stopped driving.” Carla continued by noting that stopping driving meant parents no longer brought their children to her program. “They were bringing their kids to the program and they stopped because they were afraid to drive. So Dr. Arias wrote a grant saying ‘what can we do?’ He decided to go and buy vans and buses and we pick up each of the students. All the parents have to do is pick them up from the program and take them home, so we are saving them one trip and it means a lot for them. The parents are so incredibly thankful.”

Mirroring Dr. Arias’s organization, other health-related organizations providing services to undocumented immigrants in Atlanta changed service delivery strategies. One women’s health organization, for example, changed how they provided sexual and reproductive health information to Latinas through one of their outreach programs. “People stopped coming to our programs because they were afraid of getting stopped by police. So instead of waiting for them to come to us, now we go to them. We have sexual health education parties, teach people how to use condoms, talk about preventing pregnancy, all in people’s houses. We have them invite friends, neighbors, their teenage kids, everybody.” For this organization, fear of driving

---

52 I tried to interview leaders from this organization but they repeatedly denied my request because they did not want to speak to a male researcher about their services. I met one organization leader in person while attending an immigration event in Macon, and she agreed to
dramatically reduced the number of participants in their sexual health education program, resulting in staff taking on a new burden of reaching out to community members and hosting events in their homes. “They know they’re safe if they’re at home and they don’t have to drive, so we go to their houses.”

**Differing Opinions**

Although provider interviewees shared a perspective of resistance or described how laws like HB 87 and immigrant policing had impacted their clinics, these perspectives only shed light on one side of providers’ viewpoints. In addition to interview data with providers, I also had experiences through participant observation activities at the state capitol and with local health-related organizations. During one such experience, groups of graduating medical students were taking pictures on the capitol steps and near the steps a few small clinics had set up tables with information about their services provided. At one of the tables, I met a woman representing a Federally Qualified Health Center in north Georgia, near Dalton. As we began to chat, I explained my research and hopes to interview more providers, at which point the clinic manager explained that an interview would be hard to arrange but she wanted share some concerns she had with “illegal immigrants” since we were “on the subject.”

It’s just a huge problem for us. They all come in with fake social security numbers, or maybe it’s a real one but they just pass it around and we’ve discovered this because we’ll look up a chart with the social and see the patient has lost 5 inches in height and gained 20 pounds since their last visit and uses a different name. And they get employer insurance! All those chicken plants and stuff, they give their employees insurance! They just chose not use it, so they’re coming to our clinic and using our resources because they don’t want to use their insurance!

This provider’s opinion counters other providers’ sympathies regarding immigrants’
difficulties accessing care and reflects a common but incorrect trope of immigrants using services to which they are not entitled.

**Discussion**

Findings from this chapter point to how providers responded to efforts to restrict types of care available to undocumented immigrants and thereby impede providers’ practice through immigration laws. Interviews and participant observation experiences contrast experiences of outrage with notions of uncertainty expressed through one health-related organization (the HHCGA) wanting to provide clarity regarding how immigration laws impacted providers. Efforts to improve providers’ clarity about immigration laws and their impacts on their profession were ultimately stalled, however, due to organizational changes. Overall, interviews point to how providers may resist audit cultures and specific expressions of state power that aim to control providers’ professional actions. Interview data further highlight how some providers affirm undocumented immigrants’ medical citizenship and deservingness to care.

**Resisting Audit Cultures and Specific Power Regimes**

As a form of immigrant policing, HB 87 limited the types of care undocumented immigrants could receive and implicated providers with a criminal activity if providing publicly financed non-emergency health services to undocumented patients. Components of the statute implicating providers demonstrate a form of state power merging moral notions of medical deservingness and economic accountability for medical resources as an audit of medical practice created by legislation. Although providers may be accustomed to audit cultures and restrictions on their practice, such as insurance and payment regulations and recent laws restricting abortion services (Boonstra and Nash 2014), several providers interviewed for this research described efforts to criminalize some of their professional behaviors as unacceptable.
As interview findings demonstrate, providers I interviewed described they are not necessarily accustomed to audit cultures that restrict patient populations by a status not directly related to health or care provision (such as insurance type, for example). Providers’ reactions of stressing how laws like HB 87 inappropriately encroach on providers’ professional practices point to how providers resist specific types of audit cultures. Moreover, providers like Dr. Taylor demonstrate how countering audit cultures can be possible through audit culture rhetoric of efficiency and financial responsibility, as demonstrated by Dr. Taylor explaining that assessing immigration status took time from his job and would make giving care less efficient and more costly at his organization.

Although providers interviewed expressed disapproval with laws like HB 87, disapproval of the law may be linked to various motivations. For example, some providers may object to laws like HB 87 due to humanitarian notions of providing care, as highlighted by providers like Dr. Taylor stressing the humanity of undocumented patients, or because of laws like HB 87 question medical authority. Health providers are granted a great deal of social and cultural authority based on their capacities to define life, death, and disease in institutions that provide systems of rules and organization, such as hospitals (Posner et al. 1995). When exposed to new types of bureaucratic order, providers can assert or maintain their authority by using medical knowledge and professional judgment related to care (Posner et al. 1995). As this chapter demonstrates, providers interviewed for this dissertation assert both humanitarian and professional judgment arguments against power assertions that promote agendas of undocumented immigrants’ medical undeservingness.

Asserting humanitarian and professional arguments against laws like HB 87 supports findings in social science literature discussing providers’ varied responses to restrictions to care.
for certain populations. Anthropological literature describing how providers’ practice can be managed by a power regime promoting a specific agenda, such as religiously-driven bans on abortion services, points to diverse perspectives among providers, including how policies can divide their professional communities (Mishtal 2009). In her work on abortion policies in Poland, for example, Joanna Mishtal (Mishtal 2009) describes how a law promoted by the Catholic Church that permits providers to deny abortions has divided medical professionals, led to underground forms of abortion care, and paved the way for more restrictive reproductive healthcare. Similar outcomes have also occurred in US states that have passed abortion restriction legislation (Hellerstein 2014). Like some providers in Mishtal’s work, providers interviewed in this research expressed direct objections to forms of institutional power imposing upon their professional practice, specifically objecting to statutes that limited the type of care providers could give to undocumented immigrants. Providers also mentioned underground forms of seeking care, as described in Chapter 6, and expressed concerns over possible new policies that would be more restrictive, as Dr. Layne suggested with fearing new policies would change from being characterized by not being allowed to aid undocumented immigrants, to creating a requirement to “get” undocumented immigrants. These concerns further highlight how providers in this research considered undocumented immigrants in Atlanta as deserving of medical care and objected to restricting their medical citizenship, such as relegating care to emergency or life-saving care only.

**Deservingness and Medical Citizenship**

Medical anthropologists researching providers that treat undocumented immigrants have shown how providers may make moral and racial judgments about patients’ deservingness of certain types of care (Goldade 2009) and may contribute to constructing undocumented
immigrants’ medical undeservingness (Larchanché 2012). Additionally, research on providers treating undocumented immigrants in the US details how providers articulate medical and moral deservingness to care for undocumented patients, but providers’ attitudes may not translate to improved care since structural barriers inhibit access to services (Marrow 2012). Furthermore, medical anthropologists have recorded providers’ motivations for treating undocumented patients and their perceptions of why immigrants should receive care based on notions of health as a human right or moral obligations summarized through literature on medical humanitarianism (Castañeda 2011; Minn 2010; Redfield 2005; Ticktin 2006). Providers interviewed for this dissertation recognize undocumented immigrants’ hardship in accessing services related to barriers such as fear of encountering police, and expressed deservingness of treatment based on humanitarian notions of medical practice.

This is not to suggest that all providers share this perspective, and must be situated within bureaucratic structures of care provision that leave decisions to allow patients to be treated beyond providers’ control. As Goldade (2009) notes, even if providers want to give health services to those excluded from certain types of care, such as undocumented immigrants, patients are first triaged by administrators who interface with patients in the front of the clinic, potentially limiting the types of patients providers see. This was demonstrated to me firsthand by the clinic administrator I met at the capitol who claimed undocumented immigrants had health insurance but just “chose not to use it,” and by Martina’s experiences of perceived racism with clinic administrators, as described in Chapter 6. Midlevel administrators, therefore, may require additional research attention in understanding their roles as medical gatekeepers for undocumented patients and how their roles may impact providers’ understandings of undocumented immigrants’ deservingness to care.
Adopting Market-Based Medical Approaches

In addition to suggesting how providers legitimiz ed undocumented immigrants’ medical citizenship and viewed laws like HB 87 as imposing upon their professional practice, providers also suggested how immigration laws like HB 87 fit into a broader constellation of medical surveillance and imposing neoliberal governmentality over medical practice. New licensing requirements on providers (and all other licensed professionals) and criminalizing types of care that can be provided indicate a type of control and surveillance of medical professionals expressed through immigration laws. This type of control specifically advances neoliberal forms of governance as immigration laws may create scenarios in which providers must adopt new practices common in market-based medicine. As Dr. Arias explained, immigrant policing has increased the number of no-show patients at his clinic, which led his organization to adopt practices common in other settings, such as overbooking time slots to ensure there is no financial loss for the organization.

Dr. Arias’s response to laws like HB 87 demonstrates how immigration legislation contributing to immigrant policing also impacts providers by attempting to manage their conformity with practices common in market-based medicine. Insuring complicity with neoliberal strategies in market-based medicine represents a more hidden form of provider control created through immigrant policing, concealed by more visible and overt strategies of control, such as requiring proof of legal status to renew professional licenses and managing potential patient populations by criminalizing certain types of care.

“Death by a Thousand Cuts”

Findings from this chapter further highlight how preventing types of care immigrants can receive is an example of a symbolic “death by a thousand cuts,” as Dr. Green articulated.
Gradually stripping away services available for undocumented immigrants allows for a slow, acceptable process of denying sets of rights and entitlements, and restricting types of care available to undocumented immigrants is part of this process. A “death by a thousand cuts” demonstrates the gradual processes of formally denying medical citizenship to undocumented immigrants and further speaks to how laws like HB 87 may advance efforts to promote immigrant attrition, and suggests how medical professions can be used as part of the attrition goal. Criminalizing types of care available to undocumented immigrants is therefore one of the “thousand cuts” to promote immigrant attrition and also serves to deny undocumented immigrants’ health-related rights, thus creating ways to formally deny potential claims to medical citizenship.

Examining how laws like HB 87 involve health providers in immigrant attrition efforts and deny undocumented immigrants’ claims to medical citizenship reveals how medical authority can be used in biopolitical aims to reinforce undocumented immigrants’ criminality. Just as providers are granted cultural and social authority and can resist efforts to control their profession, policies like HB 87 can use the authority associated with medical professions to advance biopolitical agendas. Criminalizing specific types of care providers can give to undocumented populations uses medical authority to assert undocumented immigrants’ criminal status and undeservingness to care, demonstrating how, as Foucault discusses, “medicine is a power-knowledge that can be applied to both the body and the population…and it will therefore have both disciplinary and regulatory effects” (Foucault 2003: 252). In this situation, criminalizing a type of care providers offer to undocumented immigrants serves as a disciplinary technique to normalize immigrants’ criminality, suggesting that their inherent criminality is so strong that it can be transferred to providers, making them criminal by association. Normalizing
immigrants’ criminality through criminalizing provider actions further asserts undocumented immigrants’ undeservingness of health services.

Providers can resist disciplinary techniques to regulate immigrant populations, resistance efforts may further implicate some providers in the illicit rhetoric that surrounds undocumented immigrants. By resisting efforts to promote a “death by a thousand cuts,” providers can be associated with undocumented immigrants’ clandestineness by providing a criminalized form of care for a stigmatized population. Providing criminalized care thus reinforces the social illegitimacy of undocumented immigrants and asserts their medical undeservingness by adding a layer of criminality through provider actions.

Limitations

Although findings in this chapter highlight the biopolitical reach of immigration laws like HB 87, the discussion of these findings is limited by the types of interviews conducted. Only providers who agreed to participate and did not feel any administrative pressures to get approval for participation shared their experiences with me. Accordingly, claims about providers’ perceptions of immigrants cannot be generalized, and the findings do not necessarily capture a representative sample of provider experiences, motivations, or responses to immigration laws and immigrant policing. Nevertheless, findings from this chapter point to how providers are implicated in specific exercises of state power and can resist forms of audit cultures while asserting undocumented immigrants’ medical citizenship.

Conclusion

This chapter underscores how immigrant policing and biopolitical expressions of state power can pervade numerous social settings and impact undocumented immigrants and medical professionals. Criminalizing types of care providers can offer reinforces undocumented
immigrants’ social illegitimacy and asserts their undeservingness of certain forms of health care. The veil of criminality cast over providers through policies like HB 87 serves to further reinforce a normalized notion of undocumented immigrants’ undeservingness to some health services and to deny recognition of their medical citizenship. Interviews from this chapter thus demonstrate how providers can be implicated in immigrant policing and how medical authority can be used as a biopolitical disciplinary technique. Similarly, interviews with providers such as Dr. Arias highlight how immigration laws can assert conformity with logics of market-based medicine, further demonstrating the disciplinary power of immigration laws and their impact on providers.

In addition to underscoring how immigration laws are techniques of power, findings from this chapter also demonstrate how providers resist efforts to deny undocumented immigrants’ medical citizenship and express notions of deservingness of health care. Providers’ resistance also extends to challenging audit cultures by using the moral and financial accountability rhetoric guiding audit cultures. Combined, findings on how providers are impacted by and resist immigration laws as biopolitical endeavors demonstrate the importance of multi-sited ethnographic attention, which can examine how power disperses through numerous settings. In the next chapter, I demonstrate how immigration regimes further extend into wider health policy and medical institution arenas, resulting in public health and hospital-related concerns.
Grady Memorial Hospital: Atlanta’s Lifeline

When driving north on Interstate 75 (I-75) towards downtown Atlanta, some of the city’s most iconic buildings rise above the tree-lined highway punctuated with traffic information signs and billboards. Along the eight lanes in each direction corridor between the northern and southern connections of Interstate 85 (known as the perimeter to locals), drivers observe signs of Atlanta’s historical and financial significance, passing symbols for Olympic Park, billboards for Delta Airlines, and clear views of the Coca-Cola headquarters. Before reaching downtown exits for Martin Luther King Jr.’s birthplace and the Ebenezer Baptist Church, the main artery of the metropolitan area dramatically curves around Grady Memorial Hospital, at which point a sign reminds motorists that “Atlanta can’t live without Grady.” Founded in 1892 and having historic importance in providing care to African-American patients (Blau 2013a; Dewan and Sack 2008), Grady has been touted as part of Atlanta’s identity (Dewan and Sack 2008). As one of the only hospitals available for African Americans, Grady was designed with the intention of providing care to black and white patients with a mission of serving the poor, fulfilling Henry W. Grady’s “vision for the New South” (Davis 2013: no pager number). Grady’s cultural significance, however, could not save it from the impacts of a healthcare and political landscape threatening the hospital’s ability to remain open.
As the largest public hospital in the state and sixth largest in the country (Gamble 2013a), neither Atlanta nor Georgia could “live without Grady.” Such a reminder may not be necessary if it were not for the hospital’s recent financial tumult that pushed the institution to the brink of closure. Like other safety-net hospitals (Wynn et al. 2002), Grady’s patient pool comprises mostly indigent uninsured patients or patients covered by Medicaid (Gamble 2013a). While other hospitals can use private insurance reimbursement funds to subsidize low Medicaid reimbursement rates, fewer than 10% of patients Grady serves hold private insurance (Gamble 2013a). Further complicating Grady’s financial stability are its funding sources; the hospital only receives governmental funding from the state and Fulton and DeKalb counties53, even though two out of ten patients come from surrounding suburban counties (Dewan and Sack 2008). Providing indigent care but not being able to subsidize the costs with private insurance payments, limited state funding contributions, and lack of funding from suburban counties ultimately led Grady to a breaking point where, in 2007, after running a budgetary deficit for decade, the hospital faced potential closure (Dewan and Sack 2008).

Central to arguments about Grady’s possible closure and financial pitfalls was the growing number of undocumented immigrants in Atlanta who sought care for kidney failure, or end-stage renal disease at Grady. The lack of a formal reimbursement mechanism for providing end-stage renal disease (ESRD) care to undocumented patients ultimately pushed Grady to close its dialysis center, which I describe in greater detail in the next chapter. An intervention from some of Atlanta’s wealthiest business leaders ultimately resuscitated the ailing hospital, but root problems that threaten Grady’s financial stability continue, including the persistence of patient dumping (sending patients from one hospital to another without properly stabilizing them), and

---

53 But receives other funds from Medicare and Medicaid, some commercial funding, and some state funding for mental health and trauma.
lack of compensation for providing indigent care. As one of the nation’s largest safety-net hospitals providing care to all indigent patients and not just immigrants, ethnographic attention on Grady can reveal concerns regarding the nation’s overall medical safety net. Safety-net hospitals are thus dubbed because they see patients regardless of their ability to pay and provide a disproportionately large amount of care to vulnerable patients, relying on federal funding to do so. Federal funds to continue providing disproportionately large amounts of care to vulnerable populations, such as undocumented immigrants, however, are decreasing with new measures of the Patient Protection and Affordable Care Act (ACA), raising questions about where the most vulnerable patients can find health services and how those services will be financed.

Figure 20: Grady Memorial Hospital seen from driving around "Grady Curve," a portion of I-75 that borders the hospital.

This chapter explores the relationship between undocumented immigrant patients, Grady Memorial Hospital, and the ACA. By describing how patient dumping to Grady ultimately
subsidizes private hospitals in Atlanta, and how the ACA changes threaten Grady’s ability to be compensated for indigent care, I suggest that as the health safety net for undocumented immigrants is further shrinking, it points to broader challenges in the public health system. This shrinking safety net demonstrates hidden efforts to increase immigrant attrition that threatens public healthcare and can be viewed as part of efforts to advance undocumented immigrants’ undesirability as patient citizens.

**Miguel: A Gwinnett Patient Seeking Care at Grady**

“You have to talk to Miguel,” Julia insisted one night at a comité popular meeting. “His story is incredible—don't you think he should talk to Miguel, Anita?” Julia asked another comité member. Anita agreed, and Julia gave me Miguel’s phone number. I was unsure of what his story was, but Julia explained that it involved hospitals and challenges Miguel had getting care. After speaking to Miguel over the telephone, we agreed to meet each other at his home for a formal interview.

Miguel lives in Gwinnett County in a suburban neighborhood across the street from a large shopping center with a grocery store, restaurants, and small businesses such as a nail salon and beauty supply store. When I arrived at his home he was just being dropped off by someone in a black SUV and greeted me in his driveway.

“Come inside,” he said, welcoming me into his home and sitting next to me on a cold, tan leather couch. Miguel immigrated to Atlanta from Guatemala in 2004 and has two children, five and two years old. Before his two year old was born, Miguel worked in a chicken wings restaurant in Decatur and commuted from Chamblee. Driving home from work one evening, he was stopped by police and arrested for driving without a license. After his arrest, Miguel decided to move and look for housing close to where he could work, taking a job in the shopping center
across from his current neighborhood. “I used to drive a car, but now they put me on probation, so I could no longer do that…I was arrested and [the police] took me to jail, so after that I knew that I didn’t want to get a car. It’s better to walk than drive, so I looked for a job close to home and worked close by.”

“Where do you work?” I asked Miguel, wondering what specifically he did since there were numerous places of work in the shopping center.

“I used to work, now I don’t because of the wound I have. But I used to work just across the street.”

“The wound?” I inquired.

“Yes,” Miguel answered, pointing to this head, which was covered by a knitted black skull cap.

“So one day, on my day off, I went to get a few things for breakfast, but when I was coming back, crossing the street here [by the house], a car passed by me, hit me, and knocked me onto the ground.”

“While you were walking?” I asked.

“When I was walking,” Miguel reiterated. “They hit me, and I fell to the ground, and when I fell, I never knew who it was or how they hit me. I don't know if it was a drunk driver or what.” After falling, Miguel entered into a coma. “I woke up in the hospital, but I woke up about seven days after [it happened] and didn’t know where I was. When someone falls like that they die because a blow to the head like that—nobody can recover from that kind of blow to the head, nobody can withstand it, so I didn’t know anything.” When Miguel awoke from his week-long coma, he was confused about his surroundings and who he was. “After it happened, I woke up, but I never understood what was happening and I couldn’t talk.”
For more than two weeks Miguel was surrounded by his loved ones but he did not recognize them. “For about 15 days I couldn’t really see who was around; my family was there with me, my wife was there, my two brothers, but I told them that I didn’t know who they were because that was my understanding; the wound did that to me. I said ‘who are these people? Who are you?’ I didn’t know they were my family.” Eventually Miguel began to recognize his family members and began asking what happened to him. “When I started to recognize them, I said ‘what happened to me yesterday?’ and they told me ‘it wasn’t yesterday. You’ve been in the hospital for almost two weeks.’” Miguel’s family was unsure what happened to him and explained to him how he arrived him. “They told me ‘we don’t know what happened to you because you came home, walking, vomiting blood; blood coming our of your mouth, blood in your nose, blood coming out of your ears; dripping blood.’” Miguel showed me from the couch where he had gotten blood all over the floor in house and resumed his story. “They told me, ‘when you came home we were worried but never knew what happened to you; we never knew. All we knew was that you went to buy something.’”

Taking off his hat, Miguel revealed the large portion of his skull that was missing, possibly as much as a quarter of his skull, giving his head a crescent shape. “They’ve removed all of this,” he said, drawing a circle around the large, concave portion of his head. “The operation was up to here,” he gestured up towards the center of his head, which seemed to have been recently shaved and hair was starting to grow back. “Up to here they took this piece out of me! I don’t have this piece of my skull, and right now I’m waiting for them to operate on this one day. I told you it was Monday [when we talked on the phone], but that’s not going to happen.”

“I remember you said you may have surgery,” I responded. “What happened?”
It turns out that Sunday they called me and told me “no, we can’t operate on you because [that portion of your skull] is in the Gwinnett Medical Center,” and they wanted to operate on me at Grady, so they said “no, because your bone wasn’t sent here; [Gwinnett Medical Center] didn’t want to send it. I don’t know what’s going on, they don’t want to send your bone because you have to pay a balance due.” But I told them if I have to do that with [Gwinnett Medical Center] then it’s the same for [Grady]. I have no money to pay for that hospital, the Medical center, because I am not working and they want me to pay them. So I found the other hospital here from the government (Grady) that gives you a card and you can…they check me—everything they check everything, lungs, bones, everything. And it’s all cheap because I have my card to admit me to the hospital.

“It’s a Grady Card?”

“Yes, a Grady Card.” A Grady Card is the identification card that Fulton and DeKalb residents receive that allows them to receive subsidized care at Grady Hospital. To receive a Grady Card, patients must prove Fulton or DeKalb County residency and for subsidies or reduced-cost care, demonstrate financial need.

Concerned about how he will pay Gwinnett Medical Center, Miguel explained he has a hard time finding work in his current condition. “If I go here to whatever job and they tell say to me ‘are you okay?’ And I say ‘yes,’ they say, ‘you don’t have a skull!’ Bosses don’t want to give me a job because I am a person that’s already an invalid, so I can’t work anymore with this injury.”

Miguel credits his newly found faith with his survival and his limited impairment. He has lost his sense of smell and taste and explained he cannot hear as well as he used to, but he is thankful that he can walk and speak. “Through the grace of God I’m like this because I have seen cases where someone had a head injury smaller than this one and couldn’t walk, but I can walk, I can talk, I can go to the store and buy something, I can pick up my kids.”
The accident that left Miguel missing a portion of his skull happened only five months before he and I met. Miguel’s attempts to contact Gwinnett Medical Center often left him frustrated; he claimed to be on hold for 2 hours or longer waiting to speak to someone who spoke Spanish before giving up or needing to take care of his children. “I take care of the kids because my wife works now, and I can’t stay on the phone if they’re fighting or something,” he explained. Overall, the frustration mounts and takes a toll on Miguel. “Sometimes I feel like a weight is over me. Sometimes I cry; if I cry sometimes I start to cry hard because sometimes I see no way out. How am I going to get my bone? And then I start to pray and ask God to take this sadness from me and move on, and I’m okay.”

Concerned about Miguel’s mental health and outrage about the recklessness of the driver who hit him, I asked if he contacted law enforcement after his accident. “Did you call the police after you got hit?”

“Well, I called the police after two months, when I left the hospital. I told them what happened and I asked them to please investigate and they told me there was nothing they could do. The officer said ‘we can’t do anything.’”

“Why not?”

“Because I didn’t see the license plate or anything, and they can’t believe it,” Miguel answered. “I had a scratched leg but I’m walking and I can see and nothing else is wrong other than the pain I’m in and this problem with my head. Many people think that a blow to the head makes you an invalid forever and puts you in a vegetative state. They told me ‘we can’t do anything’ and they didn’t do anything other than fill out a report. But they never did anything.”

Although Miguel was awake when he walked back to his home after being hit by the car, he fell into a coma in the ambulance his brother called for him. He recalled vague memories of
receiving injections in the ambulance before slipping into the coma, and heard that he had been rushed to surgery immediately upon arriving to the hospital. Gwinnett Medical Center still had the large portion of his skull, and Miguel worried he may not be able to have his surgery if he had to pay his entire medical bill before getting back the part of his bone that was removed from his head.

“Before, when they wanted to operate on me, I went to a neurosurgeon to take out the staples, and they called me and said, ‘you have an appointment on this day and when you get here you have to pay $3,500 for the visit.’ I had to pay it because I had nowhere to go, and these were metal hooks in my head. They hurt, they hurt, they hurt! I couldn’t put up with those, so I had to go.” Borrowing the money from his brother and friends in the area, Miguel found the $3,500 he needed to pay for having the staples removed. “So I paid and I went to the neurosurgeon and I told him I’m in pain [where the staples were] and I had thought he put them there to support the wound, and he told me no, just that he forgot [to take them out]. He forgot them!” Shocked that the physician had left the metal hooks in his head, Miguel was also shocked at the cost of the surgery. “I had been putting up with this pain for almost two months, suffering with this, and when I paid the $3,500 all they did was take out the staples and that was all. Then they told me ‘for your other surgery you need to bring $3,800 more.”

“You have to pay $3,800 more for the bone surgery?”

“Yes, for the operation to put the bone back in my head. They said ‘$3,800 is your balance, what you owe. Pay this and then we’ll put the bone back in. But where will I get that money? My brother already gave me $1,700, the friends we live with gave us $200 and $150, so after they said ‘bring the other $3,800,’ where will I get it? I don't have it.”
When Miguel started talking to friends about his trouble with Gwinnett Medical Center, several of them told him he should go to Grady to see if there was anything that could be done about his situation. Curious about how Miguel was able to receive care as a Gwinnett County resident, I asked if he had to show any documentation at Grady.

“I don’t have any of the documents…Grady is a government hospital and they ask you for everything. They ask you for many required documents, like where you live, where you work, a letter from your boss—all this. Bills with your name that show it’s true you live there, how much money you make, and they ask you this and then they give you a card.”

“If you didn’t have the documents, then how did you get a Grady Card?”

“I got it through my children because my children are from here,” Miguel answered.

Miguel’s answer to my question regarding his Grady Card never made sense to me given Grady’s restrictions on who can receive care. When Grady faced near-closure due to its financial crisis, the hospital initiated cost measures that more closely restricted services offered on a sliding scale to Fulton and DeKalb County residents (Pizzi 2009; Woolhouse 2004). This was partly because Fulton and DeKalb counties are the only counties contributing to Grady financially, and the hospital serves as the public safety-net hospital for them. As one provider explained, “if you live in Fulton and DeKalb, Grady is your hospital—you can go to Grady for free or pay very little out of your pocket because you pay for it with your taxes. Grady is there to serve Fulton and DeKalb residents.” As a Gwinnett County resident, Miguel should not have been able to receive care at Grady, nor should his children who live with him in his Gwinnett residence unless they used a different address.

In asking Grady providers about how Miguel may have gotten care, interviewees he may have received care as part of Grady’s tradition of being a teaching hospital and accepting patients like
Miguel in order to train new providers from medical schools at Emory University and Morehouse College School of Medicine. As part of this tradition, Grady will accept patients who are transferred from other hospitals: “Grady accepts some [patient] transfer stuff in a long tradition of the teaching hospitals accepting outside cases,” one provider explained, after I asked him about how someone like Miguel may have gotten care from Grady. “The reason they would accept someone from Gwinnett is because Emory or Grady has more specialization and can do stuff that other people can’t.” Noting the practice was common and he had justified transfers as teaching cases, the provider explained that the communication regarding the transfer typically occurs between physicians. “Their attending [physician] will call the Grady attending and the Grady attending will say ‘just send them’ and what’s going to happen is the Grady attending will justify this as a teaching case and will give the residents something to do, basically.” Miguel may have been accepted to Grady as a teaching case, but there is no way to verify whether this is true without receiving access to his patient records or speaking to the appropriate decision makers. The provider speculating about Miguel being accepted to Grady as a teaching case, along with many other providers interviewed, noted that most of the patient transfers to Grady were not necessarily teaching cases and were instead violations of the Emergency Medical Transportation and Labor Act (EMTALA). These transfers possibly constituted patient dumping—sending a patient from one hospital to another without stabilizing an emergent

54 This situation may be more nuanced than this provider suggested. Another provider, who reviewed this chapter after it was drafted, noted that Grady will accept patients because “we have a high level of expertise and we have residents who can learn, but not for learning per se.” In reconciling one provider referring to patients like Miguel as potential “teaching cases,” and another provider saying that Grady accepts patients because providers have high levels of expertise and residents who can learn, I have decided to keep the “teaching case” terminology because it still reflects how patients will be admitted to Grady if experienced providers deem a situation worthy of needing expert care that residents may also learn from.
condition (Lee 2004; Smith 2010b). Although patient dumping is illegal, Grady will accept dumped patients unknowingly, as I describe in more detail below.

Although there was no clear evidence that Miguel had been dumped from his hospital in Gwinnett, he explained that only Grady was willing to provide his operation without forcing him to pay a large sum of money, echoing other providers who suggested informal patient dumping occurring by stressing patients’ financial obligations to their hospitals, as I discuss in the following section. Miguel’s story raises troubling questions about biomedical authority and ownership over the body, but further points to a larger systemic problem related to undocumented immigrants and the overall health safety net. Miguel’s situation and stories of patient dumping, specifically, demonstrate how public hospitals like Grady subsidize private health facilities. Moreover, patient dumping of undocumented immigrants points to how hospitals play a role in constructing undocumented immigrants as undesirable patient citizens and presents a way to understand the biopolitics of a shrinking hospital safety-net.

**Patient Dumping and EMTALA Violations**

During my time in Atlanta, I learned patient dumping to Grady was a particularly contentious topic, since other counties send patients to Grady but do not contribute to Grady’s funding. One Grady board member explained that this was a large part of the hospital’s previous financial troubles. “Out of 159 counties in Georgia, only Fulton and DeKalb pay into the hospital,” the board member explained. “The money they contribute is to serve Fulton and DeKalb consumers. When Grady almost closed in 2007, we realized that there were patients coming from 138 counties and only two counties were contributing financially, so Grady had to start a rule [to restrict subsidized patient care.]” The rule the board member referred to was the residency requirement for patients that Miguel described, which involves providing proof of
Fulton or DeKalb residency in order to receive medical services (Grady Health System 2010-2014). “So Grady instilled some registration procedures and some payment procedures,” the board member noted, “so you may be able to get a Grady Card or you may have to pay cash, or you can go to Grady without a Grady Card but you have to pay cash, but it’s cost prohibitive.” The new registration procedures and residency requirements for discounted care were aimed to reduce the amount of patients coming from other counties who had already sought care in another facility. “One of the biggest culprits was Gwinnett,” the board member explained. “Gwinnett Medical (a hospital in Gwinnett County) would just say ‘go to Grady’ and that way they [didn’t] have to serve the patient. So we went to Gwinnett and said we would love to take these patients but you need to give us some money, and Gwinnett said ‘no.’”

![Figure 21: The main entrance to Grady Memorial Hospital.](image)

When I asked a Grady administrator why hospitals sent patients to Grady he explained that it was due to the hospital’s reputation for treating indigent patients. “There’s this perception if you’re poor, uninsured, undocumented, whatever, then, oh, go to Grady. That other hospitals
don't have to treat you; that we’re here for the poor and that’s what we do,” the administrator explained. “And we are here for the poor,” he continued, “but everybody’s gotta pay into that system for it to work, and these other counties and hospitals aren’t paying in. We’re the ones totally absorbing these costs.” Instead of all counties contributing to Grady’s overall funding, the hospital only receives operational funds from Fulton and DeKalb counties and the state. State funding is provided through the federal Disproportionate Share Hospital program and, as I describe later in this chapter, is an effort for the state to earn extra revenue by exploiting a federal program aimed to provide financial support to hospitals providing disproportionately large amounts of care to indigent patients. County boards determine how much to contribute to Grady, and contributions vary depending on the budgets Fulton and DeKalb Counties adopt.

Absorbing the costs for treating the area’s poor patients but receiving ever-diminishing funding from two counties led to Grady’s fiscal problems. As metropolitan Atlanta comprises 28 counties (Office of Management and the Budget 2009), patients from Cobb, Gwinnett, Clayton, Rockdale, and other counties can easily access Grady. Moreover, Grady is the busiest Level-I trauma center for the region (Grady Health System 2011-2014) and may see severe trauma patients from outside of Fulton and DeKalb counties. With its role in treating trauma patients and location in Atlanta where residents from multiple counties can seek services, multi-county or larger statewide funding to support Grady made logical sense to providers I interviewed. “Grady has been begging for a statewide system for a long time,” one provider explained. “It would be happy to absorb these patients [from other counties] if it had the financial support that was going to Gwinnett County come to Grady, but Gwinnett County doesn’t want to give up that financial support…but they also don’t want to see their patients.”

In response to the patient dumping and funding constraints that pushed Grady to the brink
of closure, Grady underwent an enormous organizational restructuring that resulted in transferring power and oversight of the hospital from an government-appointed board to a non-profit corporation. This change sparked protest from civil rights leaders and patient advocates concerned that, among other things, changes to Grady would harm black patients as a newly-appointed, white, conservative board of directors and chief executive officer (CEO) may not consider how changing the hospital would impact African Americans and indigent patients (Davis 2013). Changes to the hospital’s leadership, led by former Georgia-Pacific chairman, Pete Correll, resulted in private foundations and donors collectively contributing $250\textsuperscript{55} million to Grady’s coffers (Blau 2013a; Karkaria 2008). Of the newly generated funding, $200 million came from the Robert W. Woodruff Foundation (Davis 2013; Karkaria 2008), an Atlanta area foundation named after a former Coca-Cola leader (Robert W. Woodruff Foundation 2014). Additional changes to the hospital included laying off hundreds of employees, shutting community clinics, all while finding donors to build new treatment centers, such a stroke and neuroscience center, to attract higher-paying insured patients (Davis 2013). The financial result of the changes was Grady’s financial solvency, emerging from a $60 million deficient and $71 debt to Emory and Morehouse, whose medical faculty staff the hospital (Davis 2013). Financial solvency and donations from wealthy donors did not increase the amount of money the state or counties contributed to Grady, however, and operating support for the hospital continues to come directly from Fulton and DeKalb counties.

\textsuperscript{55} An administrator noted this figure was more like $325 million, but I could not find information to substantiate this claim.
Despite being tied to Fulton and DeKalb county funding, Grady’s financial circumstances are directly tied to other counties sending patients to the hospital for treatment. Several providers noted that this often occurred through informal means. As one provider, Dr. Tobias, said, “they wouldn’t do it formally like send a note that says ‘go to Grady,’ they just tell them ‘get in your car and go to Grady. I know you’ve got this horrendous condition right now, you probably have appendicitis, get in your car and go to Grady.’” When I asked why this informal kind of patient dumping occurs, Dr. Tobias explained that for most hospitals there was an economic motivation to not treating uninsured patients, including undocumented immigrants.

If you’re an ER doc, imagine you’re working a shift in Gwinnett, and this undocumented guy—in fact, Gwinnett has a ton of Hispanics, they are in the construction industry—and they see a guy with appendicitis. We have to operate on him and not instantly but sometime in the very near future. You’re not supposed to let the sun set on that, but they can try to call the surgeon on call and the surgeon on call’s first question is going to be “what kind of insurance does he have?” Every time. But you know of course the guy has no insurance, and so they’ll say “send him to Grady.”
Dr. Tobias continued to explain that even though ER providers participate in patient dumping, it may not be willingly, but instead because they have pressures from administration to provide services to patients with higher paying insurance. “It won’t be the hospital’s policy to do that, but it will be the practical effect of what the ER docs have to deal with. And the ER doc hates to do that,” Dr. Tobias explained. “Why should one ER transfer to another? It makes no sense. So if one ER wants to send the patient to another [ER], they don’t call the hospital’s admissions staff; you don’t go have another ER doc waiting for the appointment and redo what you just did; that’s just very bad practice.” Because it is bad practice, Dr. Tobias explained that patient dumping occurs somewhat secretly. “So you can't tell a guy to ‘hop in your car’ and send copies of the lab reports [with him] to take to Grady, because then Grady is going to call back and be like ‘what the hell? You guys saw this guy already.’ So it’s a secret, just hop in your car and just show up at Grady.” Eventually, however, the Grady physician may discover the patient had been sent from another hospital, as Dr. Tobias noted. “The patient might even say that they went to the other place and then you look in their lab history and you find out later that they had just come from the other hospital.”

Just as some hospitals may instruct ER patients to go to Grady, hospitals and providers may instruct uninsured patients to go to Grady for follow up care, which may have been the case with Miguel, demonstrating how patient dumping occurs in more subtle ways. As one provider, Dr. Green explained, “It’s become less overt, but it happens all the time. You go into the ER in Marietta and they put a splint on you and say you need to follow up with orthopedics in the week, and it used to be they would write on their prescription pad “Go to Grady,” and the patient would show up here expecting follow-up care for the fracture.” Adding to this, Dr. Green noted that some hospitals are less obvious in their recommendations for patients to seek follow up care at
Grady. “They may say, ‘follow up with this orthopedist,’ who they’re unable to get in touch with for whatever reason, maybe they aggressively don’t give them an appointment, but a nurse or someone will say ‘you know you can just go to Grady and they’ll take care of it.’” This provider, who also held an administrative position at Grady, noted that Grady began documenting cases of informal patient dumping. “We started documenting that stuff because it’s illegal under EMTALA, but we get patients every single day who show up saying ‘they told me I could come here.’ That’s been going on forever.”

Similarly, another provider explained that informal patient dumping occurs through creating roadblocks to care for some patients and that some institutions will try to avoid appearing to violate EMTALA. “What you oftentimes get is, you know, ‘we’ll stabilize you and then also you need to follow up with Dr. X,’ and then you go and see Dr. X and Dr. X says, ‘oh that will be $1,000.’ And you know, ‘I don’t have that kind of money.’ and then the doctor says, ‘well maybe you should consider going to Grady.’” Instead of directly telling patients to ‘go to Grady,’ this provider explained that some facilities and providers will place financial pressures onto patients, which will push patients to go to Grady for care. “They’ll say ‘you could follow up with me but it will cost you a couple hundred bucks,’ which of course the person doesn’t have, ‘or go to Grady.’ So we will get some version of that every day basically.” Another provider shared a similar point but thought this was not as indirect as his colleagues believed. “They’ll say ‘sure we’ll see you, it’ll cost you $500 to get in the door, by the way, they don’t charge at Grady.’ It’s not documented but it happens all the time—every day, and it’s not so indirect.”

In explaining why hospitals will “dump” patients onto Grady, one provider, Dr. West, explained that the financial justification of patient dumping made sense: “You have to remember that hospitals and healthcare facilities are businesses. Most of them are run by business officials;
they’re run by MBAs, they’re not run by physicians and it all comes down to money,” he explained. “And I don’t say that meaning that they’re all greedy,” Dr. West continued, “but your budget has to be in the black at some point or you quit paying the light bill…your profits live and die off of what comes in and out of that door…”

Although the pressures to remain profitable may play a role in patient dumping, the practice nevertheless frustrates some providers because it violates EMTALA statutes. “We’ve started reporting it to our compliance officers,” Dr. Manheim explained. “Over the past two weeks I had a couple of cases…We had a lady with a 9-mm kidney stone; her kidneys were not going to work and they basically sent her from this other hospital saying ‘you should go to Grady because you can’t afford to pay,’ and they had admitted her and operated on her and everything.” Dr. Manheim noted that Grady would be forced to absorb the cost of the patient’s operation even though the other hospital should have treated her. “That’s money the hospital’s not going to get back for that, and if you see them, that’s an emergency. A 9-mm stone should not be discharged at all.” While Dr. Manheim explained that sending patients to Grady alone was not necessarily an EMTALA violation, not treating emergency conditions such as a 9mm kidney stone violated his understanding of EMTALA statutes. “To be fair, if you don’t have insurance and you live in Fulton County and you go to a hospital and they say ‘yes you should have this procedure done,’ and it’s not an emergency, and then they tell you to go to Grady, I think that’s fair and appropriate because we are paid to take care of these patients while other hospitals may not be.”

When hospitals send Grady patients that are not Fulton and DeKalb residents, or send ER patients that should have been treated first, Dr. Manheim explained that he considers this poor professional practice. “If you’re from Gwinnett or Cobb and we don’t have an agreement, which we don’t, then you shouldn’t do that (send patients to Grady). Each county has some public
health services, and most counties’ are not robust. In Fulton and DeKalb we are it. I’m not supposed to show you this but I’ll show you anyway,” Dr. Manheim said, turning to his computer, searching for an email. “Here’s one case. So a psych patient at a different hospital; the patient gets agitated and they call the police and the police bring the patient here from the other hospital’s emergency department. This other case,” Dr. Manheim said, scrolling down his email screen, “is basically the same thing, psych patient that they brought here. They don’t want to treat patients that won’t pay them, so they send them to us.”

The broad requirements of EMTALA potentially protect hospitals from being accused of dumping patients onto Grady, however, as one provider explained. “Everybody’s answer is you have to go to Grady, but [the patient goes] to the [other hospital’s] ER and they stabilize the emergency medical condition and then they determine the patient’s condition is not acutely life-threatening. That is all that EMTALA requires you to do.” These broad requirements, this provider explained, were not necessarily medically meaningful. “The words are essentially that you have to stabilize and that is more of a legal term that it is a medical term.” EMTALA uses a “prudent layperson” standard for providers to assess their legal obligations in stabilizing a patient, but the law does not have requirements for care following stabilization (Lee 2004). Moreover, EMTALA does not have any funding associated with it, and requiring patient stabilization through treatment without compensation ultimately translates to a financial loss for hospitals. “EMTALA is a good idea generally speaking,” one provider argued, “but there’s no funding behind it. I don’t think we would have nearly as many [EMTALA violations] if the hospitals knew they would get paid by the federal government for uncompensated care,” he continued. “Doctors don’t work for free… [The federal government has] said you have to take care these people but we’re not going to pay for it. Ambiguous EMTALA requirements and lack of funds
have drawn scholarly attention to how hospitals may dump or involuntarily medically repatriate indigent undocumented immigrant patients (Smith 2010b). While in Atlanta, I heard stories of immigrants being dumped from Atlanta hospitals to Grady as part of larger patient dumping concerns, but unlike other patient dumping situations, dumping undocumented immigrants was also connected to immigrant policing.

**Undocumented Immigrant Patient Dumping and Immigrant Policing**

Although Grady has a history of receiving patients “dumped” from other hospitals, some providers noted that Latino patient dumping was directly related to threatening patients with calling immigration authorities. As a bilingual Grady staff member explained, Latino patients from other counties will come to Grady and she is sometimes given the task of telling them they are ineligible for a Grady Card and that they must seek care at hospitals in their counties. “We are not getting any monies from Cobb or Gwinnett County,” she explained. “And we try to tell patients ‘you need to go back to that County’ and they say ‘they won’t take us, they are threatening us with immigration.’” This staff member was sympathetic to immigrants’ fears of returning to other hospitals that threatened to notify immigration authorities about a patients’ immigration status because she had witnessed intensified immigrant policing and had heard stories of police stopping patients as they left clinics. “Police used to wait for people across from the clinic,” she explained. “They were looking to see how people got to the clinic—if they were driving. So if you were driving, of course, where’s your driver’s license, and of course if there is no driver’s license then right there you are being picked up. Cobb County, where I live, basically everyone was being profiled.” The staff member added that this resulted in patients being sent to detention centers, and when this happened to her patients she would instruct them to contact attorneys. “So people were being detained for long periods of time, and when I knew it happened
to some patients, I would automatically contact the consulate and I would let the patient’s family members know ‘this is the person that you need to contact so that they can investigate’ and try to get them legal representation at that point.” This staff member further stressed that threats of notifying immigration authorities of a patient’s presence was part of the informal patient dumping processes since patients would avoid seeking care in some facilities.

They won’t go to [other] hospitals and one of the things that we tell the patients is that you have a right to be serviced. No hospital can turn you away because of your legal status. If you are sick you have a right to go to whatever hospital is closest to you…You have to let them know that they could threaten all they want but legally they have to treat you and they can’t call immigration on you because you are requesting services.

The staff member also noted that she has occasionally called other hospitals to tell them their facility should see the patient. “We even call the other hospitals, we call Gwinnett, we call Henry County, we call all the hospitals and say ‘we have patients that are in your County and are your [residents] that you need to service.’ And they are like ‘no.’” When I asked the staff member how other hospitals can send immigrant patients to Grady, she explained how EMTALA’s ambiguity about follow-up care allows for the hospitals to send patients to Grady. “They are saying ‘if they come to our ER and if they are in an emergent state and then we see them, it doesn’t mean that we have to continue to see them.’ It’s that follow-up.”

Just as some undocumented patients may go to Grady for follow up care, some also consider Grady the “safe hospital” to seek services. For example, when Anita from the comité popular abruptly fell ill at work in a luxury hotel in downtown Atlanta, her husband took her to Grady. “I was throwing up blood—pure blood,” she told me at one meeting. “I left work and I got on the MARTA and I called my husband to pick me up. I don’t remember much—I think a
man helped me get off the MARTA when it was my stop, and my husband was there. He took me to Grady.” When I asked Anita why she went to Grady, she explained Grady would not ask her for a social security number to prove her immigration status, and that she was able to get a Grady Card as a DeKalb County resident. “They don’t ask for a social security number or any of that. And I got a Grady Card—I’m still making payments on my bill.”

Grady is able to provide services to patients like Anita, a DeKalb county resident who receives subsidized care because of her low income, Miguel, a patient seeking follow-up care, or patients directly dumped from other hospitals, in part because it receives Medicaid Disproportionate Share Hospital (DSH) funding. States administer federal DSH funding, as described below, and this source of funding will gradually decrease, through changes implemented as part of the ACA. DSH funding was to provide a form of reimbursement to hospitals that see large numbers of uninsured patients, but through the ACA and Medicaid expansion, the uninsured patient pool is expected to shrink, effectively eliminating the need for DSH. This logic, however, does not account for undocumented patients ineligible for purchasing private insurance on the health exchange marketplace, and that some states, such as Georgia, have not yet agreed to participate in Medicaid expansion. DSH changes ultimately translate to Grady not having a funding source to cover care for uninsured patients, and some interviewees fear this may put the hospital on the brink of closure once again.

**DSH Funding Concerns Related to the Affordable Care Act**

In 2011, Grady’s uncompensated care totaled $200 million (Gamble 2013b). For many hospitals, a large amount of funding for providing uncompensated care comes from the DSH program, which supported approximately 30% of all uncompensated care in the US in 2008 (Hsieh and Bazzoli 2012). Since the program’s creation in 1981, DSH payments have grown and
become a “lifeline” for large hospitals serving uninsured and indigent patients (Mechanic 2004), like Grady. State governments provide funding to hospitals like Grady and ultimately receive a reimbursement from the federal government through the DSH program. This reimbursement scheme undermines the program’s goal and allows for Medicaid funds to be misused for efforts other than providing patient care (Coughlin 1997; Mechanic 2004). For example, states could collect $10 million from a hospital through provider taxes, donations, or transfers, and then provide $12 million in DSH payments to the hospital; the state then receives a 50% match in DSH funds from the federal government, giving the state $6 million (Coughlin 1997; Mechanic 2004). In this example, the state ultimately nets $4 million from the federal government (Coughlin 1997; Mechanic 2004), and can potentially use the funds in ways that do not necessarily relate to patient care.

Furthermore, DSH funds can ultimately go to hospitals that do not see large numbers of indigent patients, as some providers reported was the case in Atlanta. This was particularly frustrating for one provider who viewed DSH funds as a way to assist hospitals providing care for indigent populations but saw the funds benefited hospitals that had lower numbers of indigent patients than hospitals like Grady. “DSH funds are supposed to help support hospitals like Grady,” the provider explained, “but it goes through the state, and the state’s very political, especially when it’s a white, conservative state, and you’re a poor, black patient in a hospital. In Georgia, they’ve sent the DSH money democratically to every hospital that can show it, so Northside will get DSH money while Grady’s the one providing the services.”

While DSH funds currently provide financial support to hospitals providing uncompensated care to uninsured patients, under the ACA, DSH funds will begin to diminish, starting with fiscal year 2014. Reductions to DSH funding are in anticipation of a smaller
uninsured patient pool through expanding Medicaid coverage (Linehan 2013), but shrinking DSH funding occurring in tandem with Medicaid expansion ultimately impacts undocumented Latino patients and hospitals providing care to them (Castañeda and Melo 2014). Since undocumented immigrants are not eligible for health insurance created through Medicaid expansion (Kenney and Huntress 2012), they ultimately remain an uninsured patient population and hospitals like Grady will no longer receive funding to reimburse them for otherwise uncompensated care. For one Grady Board of Directors member, this was a central concern for how hospitals would receive payments for uncompensated care after Medicaid expansion occurred. “Right now, as it stands, I am very concerned about undocumented adults once the ACA is fully implemented. I’ve not seen potential sources of funding for the population. They’ve got nowhere else to go and are not eligible for Medicaid, and there’s not going to be a billing source.”

For one provider who also served as a Grady administrator, shrinking DSH funds and recognizing that undocumented immigrants and other patients may remain uninsured raised questions about the hospital’s financial stability. “It’ll be disastrous,” he explained, adding that Grady’s financial concerns are only part of his worries: “There’s nowhere else low income patients, including undocumented immigrants, can go…I mean you can get cheap cash over the barrel health services for all kinds of people…but they can’t do with anything that’s beyond just a routine visit.” Similarly, another provider noted concerns over shrinking DSH funding and Georgia Governor Nathan Deal choosing not to expand Medicaid: “Losing DSH funding will very much negatively affect Grady’s bottom line. The other thing is the governor has not opted to participate in Medicaid expansion, so then what? So not only is your DSH funding going to be down but there’s no additional funding? So that could really mean big problems for the hospital.”
Similarly, Dr. Arias noted problems with Governor Deal not expanding Medicaid:

If you’re a lawful permanent resident, then you have to wait five years before the Medicaid. That rule goes away if the state extends Medicaid under the ACA…If Georgia doesn’t expand Medicaid then you’re going to have documented immigrants that don’t have access to care. And then that leaves the undocumented immigrants in worse shape because before there were dollars available for uninsured people that included undocumented people (DSH funds). This has gone away to pay for Medicaid expansion, and if Georgia doesn’t expand Medicaid, then there’s no dollars for the undocumented who don’t qualify for Medicaid and no Medicaid payment available for the documented immigrants. So you’re creating this bigger pool of people that won’t have access to any kind of service.

Echoing this provider’s concerns about reductions in DSH funding and not expanding Medicaid, another provider and administrator feared Grady would not be able to stay open. “Grady can really be pinched [because of DSH funding cuts] and we don’t have access to other funds through expanding Medicaid.” Fearing the worst, this provider continued, “I mean it’s going to be places like this that will have to close their doors because it’s about $100 million or $200 million that comes in to Grady from that fund and you couldn’t operate without that.”

Although decreased DSH funding and an uninsured patient population continuing to seek services may strain Grady, other hospitals may also be impacted by implications of the ACA. One Grady administrator in particular noted how rural hospitals may especially suffer from decreased DSH funding, which my further strain the entire health care system in the Atlanta area. “If the DSH money goes away from Grady that’s a big thing, but if it goes away from the rural hospitals, a lot of the rural hospitals, it’s a huge thing. Some of them may close,” the administrator explained. “A lot of them may close, including the ones where a lot of undocumented citizens in the southern part of the state who do a lot of the farming and all that kind of stuff are.” Grady officials have publicly described how smaller hospitals may not survive
DSH funding cuts and no Medicaid expansion in Georgia, and how Grady may have to cut services (Blau 2013b). If rural hospitals close and undocumented immigrants in rural Georgia are unable to access care, the administrator I spoke with thought it was more likely the patients would delay seeking care, which also had implications on Grady. “There’ve been two hospitals that have closed in the last couple of months, really small hospitals in Georgia, and there’s a theory that there may be as many as 15 of them closing if the DSH funding goes away.” Considering the implications of 15 hospitals closing, this administrator suggested that Grady could suffer from having to take care of a sicker patient group that is more costly to treat.

They are all critical access hospitals, you know 25-50 bed small area hospitals with quite honestly white poor, black poor, and Hispanic poor—that’s who’s served by that pocket. So now, with the hospitals closed, more likely the patients will just wait until the last minute before going somewhere. That’s more likely what you’ll see; like they won’t come up here because their stomach hurts, but they’ll come up here because the mass that they didn’t take care of, you know a big mass or something, that’s what you’ll see. And we’ll have to deal with it, potentially putting a bigger strain on us.

Just as this provider considered the impact of losing DSH funding on Latino immigrant patients and on Grady, a Grady staff member considered the effects on Latino patients after DSH funding disappeared, specifically hypothesizing that patient dumping would increase and that Grady’s financial constraints would result in further otherizing Latino patients. “You know what’s sad? [Undocumented patients] are going to get sent here but then they are going to get looked at as unwanted. Right now they are kind of unwanted but it’s different,” she explained, further suggesting that all Latino patients may be eventually considered “unwanted” patients as they become conflated with undocumented status. “Right now there is a bad perception but it is going to be worse when that happens. And for all Latinos. Just because they look a certain way
and have an accent then are they going to be mistreated because of the assumption that they must be undocumented. To me that is going to have a higher impact,” she added. “It is going to create an additional barrier for patients to seek health care services.”

Losing DSH funding would further contribute to inadequate care, as one provider explained. “[Inadequate funding] causes long waits, so if you’ve got finite resources and a growing population, that means poor quality care, intermittent care, people who can’t wait to get their medications, can’t get into clinics for months and months and months, so, you know, they eventually die off.” The eventual “dying off,” is an unnoticed form of death and negligence according to this provider. “It’s sort of a non-dramatic, slow attrition, but it just means the quality of what we deliver gets poorer and poorer… The trend is concierge medicine or boutique medicine for people who can afford it…If you can’t pay at all, then you wait longer and you get diseases of neglect and things you shouldn’t be seeing in a first world country.”

Adding to concerns over Grady continuing to see indigent patients in its ER while other hospitals do not, one provider explained that some hospitals are restructuring their institutions to effectively select their patient populations, freeing them of EMTALA stabilization requirements by removing ERs and no longer having to take indigent patients. “A lot of hospitals have moved away from having an ER at all,” this provider added. “They just don’t have it anymore because sometimes the ER is just not profitable…if you don’t have an ER you can sort of select your patient population, people who want elective surgery and are not really that sick but are people who can cost a lot, I mean nobody is going to come in off the street.” As this provider suggested, the increasing number of ERs closing is largely related to financial concerns, and between 1990 and 2008, 27% of non-rural ERs in the United States closed (Hsia et al. 2011). ER closures ultimately reduce access to care for indigent and uninsured patients while increasing patient
burdens on other hospitals (Hsia et al. 2011); if national ER closure trends continue through Georgia, Grady may be faced with an even larger pool of uninsured patients that it currently sees but be without adequate funding to treat them.

The impacts over potentially lost funding also extend to changing how Grady operates as a teaching hospital, as described by the provider who gave input on Miguel’s situation, who also defended a hospital’s position to not treat patients like Miguel over a long period of time. “You can almost understand their viewpoint [about Miguel] because maybe they don’t have support to take care of this guy, and if they chose to ignore that fact and go ahead and take care of him, somebody’s got to lose—Gwinnett may not be able to stay open,” the provider explained. In noting that Grady may receive patients like Miguel as a teaching hospital and not due to patient dumping, this provider explained that future cost control measures associated with the ACA may prohibit teaching cases from continuing. “Right now hospitals are running under tight margins with the Affordable Care Act provisions coming in line mostly in 2014,” the provider continued. “Hospitals are just rabid with cost control right now…More and more there is resistance to [accepting teaching cases]. The attending physician isn’t the one that’s going to resist it, it’s the finance people who are monitoring transfers, so Grady is resisting that more than it has been in the past.” The potential reduction of accepting patients like Miguel as teaching cases, combined with shrinking DSH funding and prohibitions on purchasing insurance through health exchanges thus effectively limits undocumented immigrants’ ability to receive emergency health services, reducing the efficacy and promise of a medical safety net.

Discussion

Subsidizing Private Care and Producing Patient Citizens

Findings from this chapter point to how Grady ultimately subsidizes private hospitals by
taking patients that may be dumped, formally or informally, to the safety-net hospital. These findings support other medical anthropologists’ discussions of how safety-net health centers can effectively subsidize private health enterprises. Deborah Boehm, for example, describes how Federally Qualified Health Centers (FQHCs) in New Mexico subsidized Medicaid Managed Care (MMC) by taking patients who could have been seen by MMC providers, shifting costs from the private MMC organization to the federal government (Boehm 2005). Accounts such as these demonstrate how increasingly corporatized health care changes how indigent patients enter relationships with the state and private sector for health services (Boehm 2005; Maskovsky and Kingfisher 2001). Findings from this chapter not only point to how publicly-funded safety-net hospitals support private health care organizations, but also suggests how subsidizing occurs through determining forms of patient citizenship.

Embedded within the way Grady subsidizes private hospitals is the way that undocumented immigrants dumped as patients are determined undesirable patient citizens. Private facilities that deny patients like Miguel procedures because of their inability to pay, shift the burden of care for indigent patients from private to public facilities and assert their unwillingness to care for certain patients. This process relegates patients such as Miguel to safety net institutions and determines a form of patient-citizenship associated with safety-net care. Although safety-net institutions have a long history of providing indigent care, compensation for these institutions is threatened by changes in the ACA. Medicaid expansion and DSH funding cuts challenge public hospitals’ ability to continue providing uncompensated care to uninsured indigent patients, and may eventually force safety-net hospitals such as Grady to reevaluate how they function. This could result in changing quality of care, as one provider in this chapter suggested, or potentially lead to adopting more profitable practices by abandoning commitments
to indigent care. In this respect, Medicaid expansion and concomitant DSH funding cuts may serve to reaffirm market-based medicine by quietly dismantling support for the medical safety-net and threatening its operation through providing inadequate funding. Although the medical safety net may be threatened, patients with no other avenues for care, like undocumented immigrants, will continue to need care, especially if they are dumped from private hospitals.

**Eviscerating the Safety Net for Undocumented Immigrants and Indigent Patients**

Although patient dumping to Grady impacts the amount of uncompensated care the hospital provides, DSH funding currently offsets some of those costs. With Medicaid expansion under the ACA, however, DSH funding will diminish if not disappear altogether, threatening how facilities like Grady can continue to provide care for undocumented patients. After full implementation of the ACA, undocumented immigrants are predicted to represent one-quarter of the entire uninsured population, 82% of which will be Hispanic (Clemans-Cope et al. 2012). If patient dumping of undocumented patients to Grady continues, and Grady no longer has funding through DSH to recover costs of providing care to this population, the hospital will not have a way to cover treatment costs. Moreover, the hospital’s concerns with cost that may have resulted in no longer justifying as many teaching cases, as Miguel’s potentially was, further complicates how undocumented patients may receive care.

Without a funding source for hospitals to be compensated for care and a decreased likelihood of providing care as a teaching measure, indigent uninsured and undocumented patients are consequently left to rely on an even more precarious medical safety net. Although the ACA purportedly expands access to health care through increasing the availability of health insurance, shrinking DSH funding may result in more unpredictable access for undocumented immigrants and indigent patients, generally. This may be especially true for indigent and
 undocumented patients in rural areas where critical access hospitals may potentially close as a result of losing DSH funding through ACA changes. These possibilities suggest that even though the ACA may potentially decrease racial and ethnic disparities in health insurance coverage (Clemans-Cope et al. 2012), care disparities left after ACA implementation may be deeper as resources for uncompensated care like DSH funding disappear. Deepening economic and racial disparities in care demonstrate how health reform efforts have failed to respond to health care inequalities and may reaffirm existing and documented inequalities related to market-based medicine (Rylko-Bauer and Farmer 2002).

**Immigrant Policing and Efforts to Increase Attrition**

Making access to care increasingly more challenging for undocumented immigrants and threatening the medical safety net contributes to efforts to force attrition among undocumented immigrants. Although patient dumping, DSH funding changes, and concerns over providing uncompensated care for hospitals may not be overt components of forced attrition efforts, they are nevertheless a component of immigrant policing as they effectively make life more challenging for undocumented immigrants living in the US. Processes that threaten hospitals like Grady harm one of the few access points undocumented immigrants have for care as they threaten the medical safety-net broadly. When considered through the lens of biopolitics, patient dumping, decreased DSH funding, and threats to Grady and other safety-net institutions point to a form of power managing life and death of an entire population.

As biopolitics is a form of power concerned with managing the entire species and populations (Foucault 2003: 243), the potential for decreased ability to receive care at safety-net institutions demonstrates how changes to the health system through policies such as the ACA and practices such as patient dumping are ways of managing not just undocumented immigrants,
but all indigent patients. Challenges in providing care to indigent patients may result in patients eventually “dying off,” as one provider explained, underscoring how health policies as investments in life for some populations simultaneously lack investment in other lives, echoing the race-war logics central to biopolitics. Moreover, the example of Miguel suggests how certain forms healthcare, such as emergency care for indigent patients, is a biopolitical exercise that can be an investment in life that is just enough to allow for survival but not completely respond to a traumatic health event, as evident in the large, missing portion of Miguel’s skull. Miguel’s body wears the signs of the endeavors to manage life in the most basic of ways—his care was not complete but just enough to keep him alive and functioning. This calculated form of barely managing life, or perhaps, “mismanaging life,” is codified by policies such as EMTALA that require not complete health care, but instead the bare minimum: life stabilization in emergency situations. For patients like Miguel, who are vulnerable because of their immigration status, income, lack of health insurance, language ability, and race, life stabilization is the only outcome they can hope for instead of a full investment in their overall wellbeing.

Conclusion

The complex situation involving Grady Hospital, patient dumping, and undocumented immigrants, reveals how Grady subsidizes private healthcare, how hospitals play a role in determining patient citizenship, and how policies such as EMTALA are a way to manage life that shows how the lives of undocumented immigrants and indigent patients overall are differentially valued. Denying undocumented immigrants forms of care serves to reinforce their undesirable status as patient citizens and may make immigrants like Miguel vulnerable to patient dumping from some private hospitals to public facilities such as Grady. Although public safety net hospitals like Grady have been able to absorb patients like Miguel and receive funding for
otherwise uncompensated care through DSH payments, full implementation of the ACA threatens Grady’s (and other public hospitals’) ability to continue providing care to uninsured indigent patients. Moreover, cost concerns may restrict other avenues of care for patients like Miguel, such as justifying medical procedures as a teaching case. This chapter thus emphasizes how the US healthcare system, despite recent reform efforts, continues to foster inequalities in patient care that reflect deeper social inequities demanding action. In the next chapter, I extend the hospital discussion by focusing on kidney failure and how Grady closing its outpatient dialysis center reveals fundamental aspects of biopolitics and the way in which immigrant policing and health policy intersect.
“…life and death are not natural or immediate phenomena which are primal or radical, and which fall outside the field of power” (Foucault 2003: 242).

Introduction

On October 4th, 2009, Grady Memorial Hospital closed its outpatient dialysis center, where 51 patients, nearly all of whom were undocumented, received regular dialysis care (Sack 2009c). The decision to close the center hinged on a number of financial and patient-related concerns, but because Grady is Atlanta’s largest public hospital, this resulted in dozens of undocumented patients suffering from end-stage renal disease (ESRD) being left without access to life-saving care. Although the hospital managed to negotiate and fund treatment for some patients at other locations, a small group of undocumented immigrants remains without access to regular outpatient care and continues to rely on Grady’s emergency room (ER) for dialysis, a more costly form of receiving ESRD treatment in which ER physicians are gatekeepers to care.

In this chapter, I describe how changes to Emergency Medicaid reimbursement in Georgia disqualified undocumented immigrants from receiving state-funded care for ESRD, creating new challenges for health care providers that resulted in undocumented patients relying on Grady for dialysis. Changing reimbursement policies and growing numbers of ESRD patients eventually led Grady to close its dialysis center and required locating new avenues of care for
undocumented patients with ESRD. As I demonstrate in this chapter, the dialysis center closing reveals fundamental operations of biopolitics and underscores how undocumented immigrants’ exclusion from specific health services places them in a precarious position between life and death. The changes made Emergency Medicaid as a form of exclusion for undocumented ESRD patients further demonstrate how health policies fit into a broader nexus of immigrant policing.

**Finding ESRD as a Research Topic**

In conversations about health, nearly every health provider I spoke to and several interviewees and contacts from GLAHR asserted that the dialysis center closing was a crucial component in understanding undocumented immigrants’ interactions with health care systems in Atlanta. Moreover, immigrant rights activists, GLAHRiadores, health providers, and policy makers all spoke about the dialysis center closing as a key example of how undocumented immigrants were mistreated in Atlanta and excluded from health services. For Inés, in particular, Grady’s dialysis center closing represented extreme mistreatment of undocumented immigrants. “You know about the dialysis situation, right?” Inés asked me one day, while sitting in her office. I mentioned I had seen the *New York Times* article about Grady closing its outpatient dialysis center and she urged me to speak to someone at the hospital about this. “Sí, and all those patients—they were undocumented. Many of them went back to their countries to die.”

Based on Inés’s and other informants’ suggestions, I decided to explore the ESRD situation as part of the multi-sited nature of the research. Following the dialysis story though various social networks demonstrates how multi-sited ethnography can allow researchers to investigate what participants occupying different social spaces find important. While anthropologists typically follow informants’ suggestions for what merits attention during fieldwork, the benefit of multi-sited ethnography is that when multiple participants in varying
social spaces and without regular contact with one another emphasize a specific idea they
effectively confirm the importance of the topic. In this scenario, Grady doctors, social workers,
Hispanic Health Coalition leaders, nephrology nurses at dialysis centers, GLAHRiadores, and
politicians all urged me to examine the Grady dialysis situation. Accordingly, this chapter draws
from interviews and conversations with providers, Grady personnel, and conversations with local
politicians and NGO members.

End-Stage Renal Disease and Treatment

ESRD, or kidney failure, is the fifth and final stage of chronic kidney disease and
requires dialysis or a transplant to survive (Centers for Disease Control and Prevention 2014). In
2009, more than 871,000 people in the United States were being treated for ESRD and there are
approximately 350 per one million new cases annually (National Kidney and Urologic Diseases
Information Clearinghouse 2012). ESRD incidence and prevalence are higher among Hispanics
than non-Hispanic whites (Lora et al. 2009) and nephritic disease is one of the top ten causes of
death for Hispanic populations (National Vital Statistics Reports 2010). There is no cure for
ESRD and the preferred and potentially most cost effective treatment modality is organ
transplantation (Howard et al. 2009; Meier-Kriesche and Kaplan 2002), followed by peritoneal
dialysis and hemodialysis. Complicating the potential for organ transplantation among
undocumented immigrants, however, is the moral economy surrounding perceived deservingness
to medical interventions involving scarce biological commodities such as kidneys (Wailoo and
Livingston 2006). Even though immigration status is not a factor explicitly considered in
determining organ donations, numerous scholars have written how immigration status
nevertheless shapes debates about organ recipients’ deservingness to such interventions,
specifically commenting on the case of the undocumented seventeen year old double transplant
recipient, Jesica Santillian (Rhodes 2006; Wailoo and Livingston 2006; Wailoo et al. 2006). Despite immigration status, however, hemodialysis is the most common dialysis treatment and is typically performed three times a week at an outpatient center\(^5\)\(^6\) (LaRocco 2011). The disproportionate incidence and prevalence of ESRD among Hispanic populations, chronic nature of the disease, and politics surrounding treatment and embedded notions of deservingness, make it a compelling research topic and place into a broader context of Latino immigrant health inequalities.

Anthropological literature on kidney disease has primarily focused on organ transplantation (Gordon 2000), specifically exploring transplantation from a framework of gift giving, reciprocity, and exchange (Shimazono 2008), ritual (Gordon 2000), and “rebirth” into normal social life (Constantinou 2012). Theorizing kidney disease through the issue of transplantation as a process of exchange misses the complexities of ongoing treatment for chronic disease. Examining how continuous treatment requires multiple interventions to keep patients alive allows for exploring how treatment becomes entangled in biopolitical domains such as understanding why some populations receive lifesaving care and others do not. Literature exploring kidney disease through biopolitical domains of rights to life or “right to let live” (Kaufman et al. 2006), however, focuses on elderly recipients of kidney donations, lacking attention to how constructions of otherness such as race and immigration status may also influence treatment for renal disease.

\(^5\) As of 2008, hemodialysis accounted for 93% of dialysis treatments. Peritoneal dialysis involves placing a catheter in a patient’s abdomen and requires three to four treatments per day. Both forms of dialysis can be performed at home with proper equipment, training, and assistance. For more information, see: LaRocco, Susan 2011 Treatment Options for Patients with Kidney Failure. AJN The American Journal of Nursing 111(10):57-62.
Departing from literature on transplantation, Sherine Hamdy (2012; 2008; 2013) explores kidney disease among Egyptian patients by focusing on chronic disease management through hemodialysis. Hamdy’s research points to failures of the Egyptian welfare state and implicates social structures as etiologic agents of renal disease. Like other literature on kidney failure, however, Hamdy’s work does not consider nuanced discussions of distributive medical practices that intersect with forms of otherness such as race and immigration status. Nevertheless, this chapter builds upon Hamdy’s exploration of the political and social etiologies of kidney disease, but rather than focusing on the political economy of kidney failure, it positions end-stage renal disease within a nexus of citizenship and biopolitics. Problematic dialysis care not only demonstrates an embodied social hierarchy, as Hamdy (2008), drawing from Farmer (1996; 1999), Fassin (2007), Lock (1993), and Young (1982) asserts, but also speaks to hyperactive forms of biopolitics, whereby a form of managing life can ultimately determine life and death and prolonging suffering.

**Dialysis and Chronic Kidney Disease Policy in the United States**

In Atlanta, two of the largest dialysis providers are private, for-profit corporations, DaVita and Fresenius. The presence of two large corporations like DaVita and Fresenius in Atlanta reflects the larger health care landscape for treating chronic kidney disease in the United States. The majority of dialysis centers in the US are private, for-profit institutions; although more than 70% of dialysis centers are for-profit, alarmingly, hemodialysis in for-profit centers is associated with higher risk of mortality compared to care in not-for-profit centers (Manley et al. 2004). Providing dialysis care can be a profitable enterprise, earning the treatment the nickname “dialyzing for dollars” among some providers (Greene 1981). Several providers in Atlanta referred to dialysis in this way, including one Grady emergency room physician: “It’s long been
called dialyzing for dollars because that’s how nephrologists make their money: they dialyze people.” For patients without “dollars for dialyzing,” however, dialysis can be largely unaffordable since the average annual treatment costs are nearly $90,000 per patient (U.S. Renal Data System 2013).

Privatization of outpatient dialysis centers began in the 1960s almost concurrently with the discovery that hemodialysis was effective for treating renal failure. Hemodialysis for chronic kidney disease was first done in 1960, and technological innovations spurred the growth and use of dialysis across the United States and abroad (Blagg 2007). Medical innovation related to renal disease occurred simultaneously with political action as federal committees explored the effectiveness of dialysis treatment, advocated for including treatment funding in Medicare, and eventually approved legislation to cover dialysis for some ESRD patients since kidney failure, it was argued, “was the only situation where money separated individuals from life or death” (Blagg 2007: 492). Newly created legislation, following congressional committee suggestions, thus created an exception for ESRD patients to receive publically financed care in 1972 with the creation of the ESRD Medicare program.

The ESRD program extends Medicare coverage to patients with kidney failure who are under the age of 65 and have worked long enough to receive Social Security benefits (American Nephrology Nurses' Association 2013). The program was created in part to eliminate “life committees” in which physicians would decide which patients would receive dialysis and which would not (Greene 1981), thereby allowing more patients access to life-saving care. The ESRD program also covered patients’ organ procurement costs (Rhodes 2006). Undocumented immigrants are not eligible for the ESRD Medicare program, but some states use some of their Emergency Medicaid funds to provide dialysis for them. Documented immigrants are eligible for
ESRD Medicare but benefits may not be approved for a lengthy period of time, in which case
states may use Emergency Medicaid funds to pay for dialysis for uninsured documented
immigrants waiting for Medicare coverage. Emergency Medicaid thus fills a coverage and
compensation gap for two patient populations: uninsured patients eligible for Medicare but
waiting for benefits to be approved, and in some settings, undocumented ESRD patients. Dialysis
care reimbursed through Emergency Medicaid was common in Georgia prior to state Medicare
changes in 2006, and was how Grady hospital saw undocumented patients in its dialysis center,
as one Grady employee explained to me. “Automatically any patient that was here that needed
dialysis, we would start their treatment [in the dialysis center], continue the dialysis treatment
until they got funding, which usually took about three months, and then we would transfer them
to a dialysis center. We never capped [limited] the patients here.”

Like many other states, Georgia used emergency Medicaid programs to provide care to
uninsured and undocumented patients, which allowed Grady to provide dialysis care to
undocumented immigrants facing kidney failure (Sack 2009c). In 2006, however, Georgia
changed its emergency Medicaid reimbursement practices, creating turmoil for undocumented
patients who had few options for receiving life-saving dialysis treatment. Changes made to
Georgia’s Emergency Medicaid program reflect efforts to continually limit public benefits to
undocumented immigrants and shrink entitlement programs, as outlined in policy paper drafted
by former Governor Sonny Perdue.

**Dialysis and Georgia’s Changing Emergency Medicaid Policies**

In a 2005 concept paper titled “Medicaid Modernization for a New Georgia,” then-
Governor Sonny Perdue argued that Georgia’s Medicaid program was too costly and required
fundamental change (Perdue and State of Georgia 2005). Changes proposed in the concept paper
included adopting core health values for “New Georgia,” which included personal choice and responsibility and predictable growth. These values draw from neoliberal rhetoric of individual responsibility and attempt to assert methods of control and cost containment on health care.

Following the concept paper, in 2006, the Perdue administration implemented new identification requirements to receive Medicaid (Kaiser Health News 2009; Miller 2006; State of Georgia 2005), a change that resulted in concerns over Latino children not receiving benefits because their parents lacked the ability to produce required documents (Morris News Service 2006). Among other changes, a new policy discontinued reimbursement for dialysis through emergency Medicaid funds (Sack 2009c). This administrative policy change, championed by Governor Perdue, was later codified in SB 529, which defined emergency care by federal statutes (Miller and Borden 2006). The changing definition resulted in changing reimbursement strategies, and only emergency conditions defined by federal law would receive Emergency Medicaid funds.

Federal law permits undocumented immigrants to receive publicly-financed health services for specific emergency scenarios that manifest in acute symptoms and are severe enough that lacking immediate medical attention the condition could result in seriously jeopardizing the patient’s health (United States Department of Health and Human Services 2014). Although ESRD is fatal, it is not a condition that qualifies a patient for Emergency Medicaid because the symptoms expressed are not always acute and may not necessarily lead to immediate death. ESRD is thus a paradoxical condition in that is fatal but not emergent, requiring continuous care and treatment without which will result in death\(^5\).

\(^5\) Although this is arguably true of cancer, too, which is not treated through emergency Medicaid funds, patients who miss dialysis will certainly die and the potential for mortality comes at a faster rate than many types of cancer.
The changes in Medicaid funding had profound impacts on undocumented dialysis patients who initially received care at Grady and had been placed in dialysis centers. As one Grady administrator explained, once the Medicaid policies changed, dialysis centers would not continue treating undocumented immigrant patients. When their care was terminated because the for-profit dialysis centers no longer received reimbursement for providing dialysis to undocumented immigrants, many patients returned to Grady and other hospitals seeking treatment. As one Grady staff member explained, “when the Medicaid funding was cut, those patients that were in the dialysis centers that we had placed and had no legal status started coming back to the emergency rooms. It was not just our emergency rooms, but all of the emergency rooms because they were all in different counties.”

Faced with a large patient group needing continuous care and without a way to be reimbursed, some hospitals began telling undocumented patients not to return for treatment and threatened some patients with calling immigration authorities if they tried to seek dialysis. “So the hospitals were being overworked,” a Grady staff member explained, “and they were telling the patients that they could no longer provide them with dialysis and to stop coming or they would report them to immigration. So they all started coming to us.” Restrictions from dialysis centers and the threat of being reported to immigration authorities limited undocumented immigrants’ options for treating kidney failure. As a result, patients seeking care at private hospitals went to Grady for dialysis, but the increased number of undocumented patients being provided with unreimbursed care pushed the hospital to a financial tipping point (Sack 2009c).

**Grady Treatment and Closing the Outpatient Dialysis Center**

Although Grady absorbed many of the ESRD patients other hospitals would not see, providing services that were no longer reimbursed through Emergency Medicaid forced Grady
into a financial hardship. One Grady administrator explained that the hospital was at the brink of closing entirely. “We were in the red. It was so bad that it got to the point where we either had to close the dialysis center or we had to close the hospital.” Administrators and hospital board members publically spoke about how Grady’s dialysis center contributed to the hospital’s overall financial problems (Dewan and Sack 2008; Rizzo 2007; Sack 2009c; Schneider 2009), and expressed concerns over the consequences of closing Atlanta’s largest public hospital and Level-I Trauma center. As one administrator explained, “we’re talking about a $1 billion a year hospital, and we were going to have to close because of this [dialysis problem]…We didn’t want to [close the center], but we were the only ones taking these patients that needed dialysis.” Grady taking on the burden of indigent dialysis patients came up in every interview with Grady providers and staff, all of whom discussed a series of New York Times articles documenting the problem (Dewan and Sack 2008; Sack 2009a; Sack 2009b; Sack 2009c; Sack 2009d; Sack 2009e; Sack 2010; Sack 2011; Sack and Einhorn 2010). The dialysis center was not solely responsible for Grady’s financial situation, however, as government funding for the hospital and increases in uncompensated care overall threatened the hospital to maintain financial solvency (Sack and Dewan 2007). Low reimbursement rates further figure into public hospitals’ financial troubles; Medicaid reimbursement rates may not cover the entire cost of some forms of care, and public hospitals like Grady have had to dramatically reduce some services, leading hospitals in places like New York and Las Vegas to cut children’s mental health programs and close mammography centers and outpatient oncology clinics (Sack 2009d).

As the threat of closing Grady become imminent, continuing dialysis for uninsured patients was no longer a viable option, leading administrators to close the dialysis center in 2009. Closing the center sparked significant uproar from Atlanta-area activists and led patient
advocates to sue Grady for issuing what they regarded as a death sentence for 51 patients (Park 2009; Sack 2009a; Sack 2009c; Sack 2011). Stories of dialysis patients, such as 23-year-old Ignacio Lopez, appeared in national newspapers, in which the young immigrant was quoted wondering how he would survive without dialysis (Sack 2009c; Sack and Einhorn 2010). Despite local activism and media attention, legal action proved to be unsuccessful in stopping the hospital from closing the outpatient treatment center. Despite closing the center, however, Grady ultimately negotiated dialysis care for the patients by agreeing to pay DaVita or Fresenius for providing services (Miller 2011a; Miller 2011b). In addition to making deals with private, for-profit dialysis centers, Grady also offered medical repatriation to its undocumented ESRD patients. As the social worker in charge of finding placement for the patients explained, she attempted to offer options to patients and follow their wishes. “If the patients had family members and wanted to return back to their country we would give them the medical information and try to set them up with dialysis centers over there.” Cost played a factor for the mostly Mexican patients offered medical repatriation. “The cost for dialysis [in Mexico] is $100 as opposed to $500 per treatment here and it is three times a week…So that was something some patients did accept.” For those unable to afford care but still wanting to be repatriated Grady found dialysis through an agency in Mexico:

Other patients, we worked with another agency, MexCare, and they were willing to work out the details of providing what we would pay for three months of dialysis treatment until they were eligible for government assistance...We would try to work deals with them in terms of transportation, setting up a place to stay, whatever it was that we were going to try to help them to relocate.

This social worker, Aricél, explained she became deeply connected to the dialysis issue and it affected her personally. “I did everything I could for them.” As the situation surrounding
closing of the dialysis center became increasingly controversial, Aricél’s name appeared in newspapers across the country. “I had my mother calling me from New Jersey saying ‘your name is in the paper, and they mentioned you on TV!’ What’s going on down there?” For Aricél, finding care for the patients was a top priority once the hospital closed the outpatient dialysis center, but for some patients who chose medical repatriation, care was still problematic. Thirty-four year-old Monica Chavarria, for example, chose the medical repatriation option when Grady’s dialysis center closed, leaving her husband and one of her children in Georgia (Sack 2009b). As Kevin Sack (2009b) reported in his extensive New York Times coverage of the situation, Monica exhausted the Grady-provided support in Mexico and she can temporarily afford dialysis by dipping into the savings she and her family have put aside in hopes of her receiving a Kidney transplant.

For patients who did not chose medical repatriation, Grady entered an agreement with the private, for-profit dialysis centers. “Once we had [medical repatriation figured out],” Aricél explained, “then those patients who had families here and did not want to leave, there was an agreement made with Fresenius, and we had the patients sign the contract that they were going to be moving to Fresenius facilities and that is where dialysis was going to be.” Although Grady and Fresenius made a care agreement, it did not guarantee lifetime care and was limited to one year. “What happened at the end of the year?” Aricél asked. “The contract is now terminated, and so of course Fresenius says ‘well we have no more contract for you, so you have no more dialysis.’ By this time it’s about 20 patients, 20 that are still there, that need dialysis that have no documentation.”

After the initial one-year contract between Grady and the dialysis centers expired, Grady extended the contracts to continue paying for services. Although Grady extended contracts with
Davita and Fresenius, public opinion of the hospital seemed overall negative (Miller 2011a; Park 2009), a point Aricél emphasized. “Of course we had the protesters who said ‘Grady is killing us, they are not renewing our contract,’ but really what other hospital would pay? We were again the hospital that was like the bad one, so again Grady again extended the contract for these patients” (Miller 2011a; Miller 2011b).

Grady eventually extended contracts with Fresenius to treat undocumented end-stage renal disease patients twice and included an option for continued extension until the end of 2014 (Sack 2009c; Sack 2011; Williams 2011b). Although the hospital arranged dialysis for patients, several interviewees felt Grady had been portrayed unfairly in the media. Recognizing the ethical concerns over leaving dialysis patients without regular care, one employee explained the position of the hospital in relation to its funders and county constituency:

Grady was the one seen as the bad hospital throughout all of this and we were the only hospital that basically was facing this. We’re supposed to provide for patients, on one hand, but on the other hand you’re supposed to provide for your patients that live in the county58, Fulton and DeKalb, that are taxpayers. If we can’t provide them the service because we are providing for somebody else, we are doing a disservice.

After Grady closed its outpatient dialysis center and renegotiated contacts with private centers, some patients who were not in the initially negotiated pool of patients sought treatment through the emergency room. These patients were never placed in private dialysis centers, so Grady continues to provide them with services through the hospital’s emergency room.

“When You’re Sicker, Come Back:” The Emergency Room as a Last Resort

For many undocumented immigrants, emergency room care is often the only source of health care available. For some end-stage renal disease patients in Atlanta, emergency rooms are

58 See chapter nine regarding Grady’s mission to serve patients in Fulton and DeKalb Counties.
the necessary spaces keeping them alive on a weekly basis, multiple days a week. Although Grady no longer has an outpatient dialysis center, the hospital provides emergency dialysis to patients who come into the emergency room. With no alternative for care, some undocumented end-stage renal disease patients who do not receive care through private outpatient centers must report to Grady’s emergency room every time they need dialysis, two or three times a week. This becomes a costly and complicated administrative endeavor, requiring hospital admission and treatment, as one Grady administrator pointed out. “The complicated thing is that all these patients have to be admitted to the hospital, so they get admitted in the ER and are usually here for a day or two. Then they go home, and then they come back a couple of days later, so unfortunately it’s this never-ending vicious circle.” Expanding on this further, Aricél explained the challenges in only being able to admit the end-stage renal disease patients when they have an emergent condition:

We still have around 10 or 12 [of the undocumented patients] and we see them every week, some of them a couple of times, who just come for dialysis, but because they don’t have services through the County or whatever they have to come to the emergency room. If it’s not an emergency then we are supposed to discharge them, so if they don’t have an indication for anything emergent we can’t admit them for routine dialysis…So we do from time to time send them back home and we tell them basically, I mean, I hate it, but we tell them ‘when you’re sicker, come back’ because they don’t have access to services…if you were a legal citizen and you had kidney failure you’d get Medicaid, but if you’re not a US citizen you don’t, and you’re not eligible because I know the hospital doesn’t get paid for it.

Without having an emergent condition, hospitals cannot provide emergent care with a way of being reimbursed, leading some ER providers to double check with patients before they sent them home and tell them to “come back when [they’re] sicker.” Some providers explained they would make absolutely sure patients were not experiencing emergent conditions such as
shortness of breath or chest pains before sending them out of the hospital, as without these conditions patients are discharged until they are ill enough to warrant receiving emergency treatment.

Beyond the patient care perspective, some providers commented on the enormous financial and temporal inefficiency of having dialysis patients continually report to the ER. Commenting on cost in particular, one emergency room provider who tends to these patients noted that it would be easier and more cost effective if the patients were able to have regular dialysis. “[They come in] two or three days a week to get dialysis, and you’re talking about emergency care, which is way overpriced anyway, and that’s two or three times a week 52 weeks a year. That’s a lot of money and it’s hugely inefficient!” Not all ESRD patients are able to make it to the emergency room for dialysis three times a week, however, which may exacerbate their condition. As Aricél pointed out, for patients who cannot make dialysis appointments as frequently as they should, the results are severe. “For dialysis patients [treatment] is usually three times a week. Because they are not getting it three times a week, they are coming in sicker. So let’s say they are coming in once every eight days, once every 10 days. Their life expectancy a shortened, they have more comorbidities, and that’s the issue.”

Despite inefficient care and increased potential for experiencing greater degrees of illness, the emergency room technically keeps undocumented ESRD patients alive, but “just barely,” as one provider explained. “They’re barely being kept alive,” he said during an interview. “The dialysis is just enough to keep them living, and that’s about it.” This provider’s particular comment points to the underlying biopolitics of undocumented ESRD patient management, whose lives are managed by a bare minimum (but costly form) of medical intervention.
Discussion: Managing Precarious Life and Health Policy as Immigrant Policing

Denying undocumented immigrants dialysis through changes in Georgia’s emergency Medicaid payments builds upon the continued restriction to health services for undocumented immigrants and further places those with severe chronic illnesses such as ESRD in increasingly precarious positions for obtaining necessary life-sustaining care. The type of care ESRD patients receive, however, is a form of care that, as one provider put it, “barely keeps them alive,” echoing other researchers’ descriptions of patients whose care and lives are bound in political processes as being the “living dead” (Petryna 2004; Ticktin 2006). As definitions of “emergent” do not necessarily encompass notions of fatality or severity, undocumented patients with ESRD occupy a space of medical ambiguity, having an illness that is severe and fatal but not emergent, requiring continuous treatment and financial investment. Unlike other potentially fatal chronic diseases, however, ESRD requires a type of treatment that if missed will in fact result in death in a short period of time. Beyond continuing the history of medical exclusion, the dialysis situation underscores the way in which health services are shaped by biopolitics and driven by political economy.

The closing of Grady’s dialysis center and challenges undocumented ESRD patients face might suggest that when immigrants’ bodies require economic investment that exceeds their labor and economic production potential, that they no longer merit lifesaving treatments that in the aggregate may amount to substantial costs. This political economy of life itself underscores the very devaluing of immigrants’ lives. Expanding this further, examining the biopolitics of ESRD care reveals how undocumented ESRD patients are managed through a governance of medical uncertainty and precariousness.
Altering Emergency Medicaid eligibility rules established new systems of control and surveillance (Bernauer and Mahon 1994; Foucault 1979) for managing undocumented immigrants’ lives. While systems of control are necessary for cost containment in market-based medicine, changes in Georgia’s Medicaid policies narrowly excluded a category of patients rather than broadly applying cost control efforts, effectively determining rights to continue living for patients with ESRD. Following Foucault’s assertion of sovereign power exercised through the “right of the sword” (Foucault 1978; Foucault 2003) denying a payment scheme for undocumented ESRD patients to receive dialysis was an effective exercise of sovereign power over the right to life and death, especially for a condition in which missing care rapidly results in death. Operative denial of dialysis care and resulting potential for death, however, should not be understood as an example of Agamben’s “bare life,” nor are undocumented ESRD patients turned into a “living dead” homo sacer stripped of political rights and entitlements and left to die (Agamben 1995). Rather than being left to die, undocumented ESRD patients are left barely living; their lives entail constant uncertainty of treatment and are marked by a type of suffering fashioned through precarious access to life-sustaining care that other ESRD patients do not have.

Undocumented immigrants are not just left to die due to kidney failure, as an Agamben-oriented theoretical emphasis on thanatopolitics may suggest, but they are left to live and suffer in uncertainty about treatment, living and knowing that treatment is available but precariously obtained and out of consistent reach for them but not for others. The construction of an us/them treatment antagonism highlights the nature of the biopolitics of dialysis, pointing to how life and suffering are managed, particularly for undocumented patients who are denied access to life sustaining care through the ESRD Medicaid program because of their documentation status. Whereas other patients receive care through insurance or eventually receive care through
Medicare, undocumented immigrants are repeatedly pushed to the brink of death and must hope contract negotiations are successful, navigate administrative hurdles through emergency rooms multiple times a week, or chose medical repatriation to continue living. Life with ESRD is thus managed through the placement of administrative obstacles and concerns over medical costs that undocumented immigrants are made to navigate but other populations are not. Life is therefore an unstable and uncertain reality for undocumented ESRD patients, reflecting the overall instability of their situation in the United States, being stuck somewhere between life and death and resident/noncitizen. In this case, managing life translates to managing and ensuring uncertainty for undocumented immigrants.

Managing uncertainty of treatment emphasizes how treatment in market-based medical systems can be a biopolitical tool with different treatment modalities based on arguments of cost and medical rationing. This may implicate providers in biopolitical processes and involve them in surveillance activities, such as granting treatment on diagnoses of emergent conditions. Providers, however, can challenge these activities by engaging their own notions of morality and ethical conduct by ensuring patients do not have an emergent condition before discharging them from the ER and avoid having to instruct them to “come back when they’re sicker.” Providers can thus fill an ethical void by tapping into a moral economy that recognizes the appalling outcomes of being denied dialysis but not having a formal way to provide care. This is an outcome of simultaneously denying immigrants ESRD treatment but recognizing the horror of these patients being left to die. When immigrants were allegedly “left to die” by Grady closing its dialysis center, public outcry suggested how immigrant patients deserved life-sustaining care, but the moral rhetoric of care focused on not allowing the patients to die, rather than asserting immigrants’ rights to live and be provided care through publicly supported means.
Lastly, the ESRD situation throws into view how life itself can be managed through technologies and interventions organized through bureaucratic orders. Undocumented ESRD patients are managed through medical interventions that must occur by reporting to the emergency room and relying on a physician to determine an emergency state that qualifies them for care. This process makes undocumented immigrant ESRD patients’ lives more challenging as something regularly necessary becomes highly burdensome. When considered in the context of the rest of the dissertation findings and immigrant policing, constraining access to dialysis for undocumented ESRD patients echoes previous social service reforms that restricted immigrants’ access to health services, including the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) and the Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA). These reforms limited the medical safety net for undocumented immigrants unless states made other provisions, as discussed in chapter two, and Georgia’s changes to Emergency Medicaid and passage of SB 529 further restricted what services undocumented immigrants could receive, removing access to ESRD treatment. This increased restriction further implicates health policies as forms of immigrant policing justified through neoliberal rhetoric or cost control individual responsibility. Unlike PRWORA and IIRIRA, however, the consequences of limited ESRD treatment through restricting Emergency Medicaid are fatal.

ESRD restrictions further speak to the efforts to increase immigrant attrition through “self-deportation” (Kobach 2008) but add to this “theory of attrition” (Alexander and Fernandez 2014; O’Leary and Sanchez 2011) efforts that manage undocumented immigrants’ lives in deeper ways. As a health policy that advances immigration enforcement efforts, ESRD restrictions that can result in death have reinforced a personally biological form of biopolitics. Just as immigrant
policing can result in moving enforcement efforts into increasingly local and intimate spaces such as the home, as described in chapter seven, efforts to manage ESRD patients show how immigration control strategies can become individualized and have biological impacts.

**Conclusion: Being Stuck and Barely Alive**

If the dialysis situation for undocumented immigrants points to any large concerns with the health system in the United States, it is that Emergency Medicaid is not at a catch-all safety net, even for patients dangerously close to death. The severity of ESRD and trouble finding care for undocumented patients points to the horrific health inequities present in the United States, and further speaks to how life is managed. While Inés explained that many of the dialysis patients from Grady went back to their country to die, and other providers echoed this, many of those that remained in the US continue to receive ESRD care in unpredictable ways through the emergency room and survive a precarious form of life. For undocumented immigrants in Atlanta needing dialysis, care continues to be uncertain and is a form of managing life that aids in producing a type of undeservingness that reflects the broader uncertainties and liminal positions of undocumented immigrants in the United States. As one nephrology nurse for Fresenius explained in talking about an undocumented patient, when an undocumented patient receives care it does not always entail options: “If the [patient] leaves for 30 days Fresenius is not going to give his bed back…He can’t go on a trip to Mexico to go visit family for a couple months, he can’t get sick and go to the hospital for an extended amount of time…he’s just stuck there, waiting to die.” Being “stuck” as a dialysis patient “waiting to die” not only speaks to the gravity of the condition but also reflects undocumented immigrants’ liminal position in the United States. Being stuck, waiting to die, is therefore perhaps the strongest type of biopolitical exercises in letting live, where life is managed, but people are “just barely” being kept alive.
CONCLUSION

Introduction

On my final Monday night meeting at GLAHR, Inés continued an ongoing conversation about immigration reform, explaining any kind of reform effort that passed would exclude a large number of undocumented immigrants, including people with prior removals and convictions. “That will just make it worse for us because there will still be a large number of ‘illegal’ immigrants left, and then they will say ‘what’s wrong with you? Why didn't you fix your status the last time?’ If we are going to have reform we need reform for everyone; we need amnesty for everyone, not just a few, but for all.” Her passionate plea inspired head nods but filled the room with a sober sense of contemplation. “We have to continue to fight for amnesty for everyone, to stop breaking apart families and destroying our communities. We have to continue to fight.” Inés’s concerns underscore how policy can divide populations; any proposed immigration reform may continue to divide immigrants through exclusions from the reform, a particularly salient and prescient fear given the Obama administration’s recent announcement extending deferred action to some parents of US citizens (DAPA). DAPA provides temporary relief from deportation to a limited number of undocumented immigrants living in the US with US citizen children. This type of near-citizenship by proxy is an example of precisely what Inés feared; an immigration reform with limited impact, resulting in ineligible immigrants remaining in precarious positions and perpetuating immigration status-related vulnerability. After discussing possible immigration reform, in a somewhat abrupt transition the mood lightened as our attention turned to a farewell party the GLAHRiadores had organized to mark my last
meeting. Inés gave me a bag with GLAHR stickers and the official GLAHRiador t-shirt that only GLAHR members wore, distinct from other GLAHR garments. I gave an emotional farewell statement over a slice of cake, and everyone chanted “te queremos, Nolan, te queremos!”

Throughout this dissertation I have provided examples of how participating with immigrant rights groups, most notably with GLAHR, provided me with a better understanding of how immigrant policing affected immigrant communities, shaped undocumented immigrants’ health, and had broader health-related impacts. Findings from this dissertation demonstrate how immigration policy pervades multiple social levels to shape undocumented immigrants’ health, implicates health providers in governing activities, and reveals sharp inequalities in the overall health system. I have described how immigrant policing advances fear-based governance as a technology operating on populations and individuals, shaping individual health behaviors, destabilizing family relationships and playing a role in the potential for intimate partner violence. I have further described how immigrant policing involves health providers who can resist efforts to control undocumented immigrants, and how immigrant policing efforts fit into a broader context of health-related exclusions that can result in undocumented immigrant patients being “dumped” from one hospital to another, or left to suffer in uncertainty with a fatal chronic disease like end-stage renal disease. In this final chapter, I provide additional thoughts on fear as a form of creating ideal types of citizens and suggest a need to examine policy as part of mutually-reinforcing social phenomena that directly results in deleterious health impacts, borrowing from a syndemic understanding of health and illness. I also reflect on the engaged, multi-sited research that resulted in this dissertation and consider future related research.
Fear, Neoliberal Citizens, and Hypercitizenship

Throughout this dissertation, I have argued how experiences of immigrants like Sandra, described in chapter six, demonstrate how immigrant policing perpetuates a type of fear-based governance that results in fashioning a self-reliant citizen who hesitates to use public services. Sandra’s fears of encountering police lead her to seek health services at locations where she questions the quality of the treatment she receives, but she continues to seek care at these locations because she views them as spaces free from the threat of police. Similarly, teatro popular events in which GLAHRiadores promote cautious driving and careful vehicle maintenance emphasize how some immigrants take efforts to avoid police detection. These findings point how immigrant policing plays a role in creating the “hypercitizen” Castañeda and Melo have described: the citizen who routinely checks his or her vehicle and drives cautiously to avoid the scrutiny of a harsh immigration regime, thereby embodying a hyperbolic form of cautionary living (Castañeda and Melo 2013). The development of hypercitizenship suggests an emerging biopolitics of caution, which deserves additional research attention as undocumented immigrants must be overly cautious in routine, mundane activities to avoid discovery and potential deportation. Caution and its connection to fear as a governing strategy emphasize how fear-based governance promotes a type self-reliant and temporary citizen who makes minimal demands upon a state. As other researchers have argued, fear of having their immigration status negatively impacted has resulted in undocumented immigrants avoiding public services as a way of not “being a public charge” (Horton 2014). Avoiding public services demonstrates how some immigrants ultimately act in ways that comport with neoliberal ideals of individual responsibility even though they may be shaped by fears of deportation. Fear is not the only way of advancing a type of ideal immigrant citizenship, however, as recent immigration reforms demonstrate.
The emergence of hypercitizenship as a way of living points to problems with immigration reform efforts that reinforce notions of ideal immigrant citizens. Current immigration policies, for example, advance efforts to produce and praise the ideal immigrant as a self-reliant, educated, highly-motivated and able to overcome adversity. This is best demonstrated by the Deferred Action for Childhood Arrivals (DACA) initiative from the Obama administration, which grants (among other limited benefits) temporary relief from deportation to eligible undocumented immigrants who arrived to the US as children. Although a temporary solution for some immigrants, becoming “DACAmmented” is a processes that typically benefits immigrants with higher education levels and access to community resources, reproducing inequalities and differing opportunities for those who remain “unDACAmented” (Gonzales et al. 2014). Ultimately DACA privileges a type of immigrant as an ideal potential citizen while stigmatizing others. The DACA situation thereby reproduces historic forms of classifying immigrants and ordering their desirability based on attributes such as age, education, and ability to pay DACA costs, not unlike the way immigrants’ desirability was judged based on race and potential to become a public charge (Fairchild 2004; Sainsbury 2006), as described in chapter two.

Similarly, the Obama administration’s recent extension of deferred action to adults with US citizen children (U.S. Citizenship and Immigration Services 2014) privileges undocumented immigrants with children, determining belonging as potential citizens partly by parenthood and raising US-born children. Like DACA, the most recent deferred action, announced on November 20th, 2014, fails to be an effective solution for current immigration concerns at is provides a reprieve from deportation for only three years and is only estimated to assist approximately 5 million of the 11 million undocumented immigrants currently living in the US (Patten and Passel
The temporary nature of deferred action allows for continuing fear-based governance since the reprieve from deportation may expire without renewal, potentially altering the effect of fear-based immigration enforcement as some immigrants may fear their temporary status could expire in the future. DACA and the most recent deferred action thus continue to manage undocumented immigrants’ lives through uncertainty and precariousness, and the threat of deportation may still loom in the future. Moreover, policies like DACA and DAPA further uphold a white and heterosexual power regime through determining types of ideal citizens.

The temporary nature of DAPA and DACA echo historic forms of limiting full citizenship to white populations (white men, specifically), restricting Latino immigrants’ sets of rights on a temporary and renewable basis much like the way non-white populations historically had been restricted from full rights and citizenship. In this respect, DAPA and DACA underscore how the legal system supports racial hierarchies (Bell 1995a; Bell 1995b; Delgado 1995; Freeman 1995). Beyond simply supporting racial hierarchies however, policies like DAPA reinforce heterosexist citizenship ideals as eligibility for the program hinges upon having US-born children. As I argued in chapter seven, non-heterosexual and childless immigrants are missing from family-related resistance efforts to respond to immigrant policing, and childless immigrants are specifically excluded from DAPA eligibility. DAPA therefore further reinforces notions of ideal citizenship by privileging heterosexual citizenship; if immigrants are not producing US-born citizens, they are not eligible for reprieve from deportation. Future research on immigration reform efforts and immigrant policing must pay specific attention to how non-heterosexual undocumented immigrants’ experiences differ from heterosexual immigrants’, and how being an undocumented lesbian, gay, bisexual, or transgender (LGBT) immigrant results in uniquely constrained possibilities. Similarly, future research on immigrant policing and the
consequences of immigrant detention, in particular, must focus on how detention and deportability reproduce racist and heteronormative power dynamics.

**Race, Policing, Detention, and Citizenship**

Just as DACA and DAPA reinforce racial hierarchies and ideal forms of citizenship, so too do the processes associated with policing, including detention and deportation. Following Dorothy Roberts, who links police terror of minority populations and mass incarceration with supporting racial hierarchies (2007), future research on immigrant policing must also examine policing from the aspect of detention and deportation. The American Civil Liberties Union (ACLU) of Georgia has documented abuses in immigrant detention facilities, including physical and verbal abuse, inadequate and delayed medical care, and allowing for unsanitary conditions (in at least one instance a female detainee was given soiled undergarments resulting in an infection that scarred her legs and genitals) (Cole 2012: 16). Beyond documenting these concerns, research attention must focus on how detention facilities are a part of an overall policing regime serving to limit undocumented immigrants’ rights and reinforce racial hierarchies, following scholars such as Dorothy Roberts (2007) who have demonstrated how prisons and policing serve to undermine African Americans’ rights in the United States.

Borrowing from Loïc Wacquant, Roberts argues that mass incarceration efforts targeting black men in the United States is situated within a lineage of controlling African Americans, including slavery, Jim Crow systems, and urban ghettos (Roberts 2007; Wacquant 2001a). According to Roberts, prison expansion and law enforcement tactics resulting in mass incarceration of African Americans undermine civil rights-era reforms and demand action (Roberts 2007). Providing context on how African American imprisonment is situated within broader systems of policing, Roberts argues that incarceration occurs through police terror and
brutality targeting African Americans, demonstrating how racialized terror and systems of control are embedded in the contemporary criminal justice system (Roberts 2010: 279). The consequences of racialization of incarceration and police terror include lost rights and exclusions in full political citizenship as large numbers of African Americans have lost voting rights because of their convictions (Roberts 2010; Uggen and Manza 2002). Ultimately incarceration and racialized policing have allowed for African Americans to be politically disenfranchised, underscoring how policing can be used to assert and result in differential sets of rights and entitlements, and ultimately support white political hegemony. Incarceration and loss of voting rights, demonstrates, as Michelle Alexander powerfully argues, how Jim Crow-era discrimination persists in a redesigned racial caste operating through the criminal justice system that sanctions discrimination against criminals (Alexander 2012).

Considering how policing and incarceration can uphold white power regimes, future research on immigrant policing can similarly consider how policing and incarceration not only perpetuate racialized social hierarchies, but also may further result reformulated types of citizenship by articulating differing sets of rights and entitlements for immigrants. As Roberts argues, police terror and policing itself can support a white power regime, but viewed together with incarceration techniques, or in the case of immigrants, detention techniques, research on immigrant policing may reveal additional insights on how prisons and police activities operate as systems of control to perpetuate racial hierarchies. Additional attention is thus needed to further explore the health-related consequences of such policies, particularly on undocumented LGBT populations, requiring research on how policing and detention interact with immigration status, race, and sexual orientation to shape differing experiences of oppression. Closely examining health-related impacts of policy requires a framework that implicates social phenomena in poor
health outcomes. To better examine the relationship between policing and other social phenomena, the concept of a syndemic, mutually reinforcing social and physical conditions that lead to deleterious health impacts (Singer 2010), may be useful in inspiring future work.

**Pathogenic Policing as a Policy Syndemic**

Findings in this dissertation highlight how immigrant policing can shape the types of health services undocumented immigrants seek, where they seek care, and the role of immigrant policing in shaping preventive health behaviors. Stories from chapters six and seven specifically point to how immigrant policing may result in avoiding types of care and services, implicating policing in health domains. In describing policing efforts that directly affect health as “pathogenic policing,” I point to how immigration policy and police practices impact undocumented immigrants’ health, largely through perpetuating fear-based governing strategies. Multilayered policing efforts understood through a health lens further suggest how state and federal immigration policies and local police practices work synergistically to affect mobility and produce negative health consequences. Findings from this dissertation point to the synergistic effects of different types of immigrant policing that interact to shape health behaviors and health outcomes.

The reinforcing interaction of policy and poor health consequences deserves additional research attention beyond Atlanta. While some research directly implicates policing in health conditions and outcomes (Alexander and Fernandez 2014; Bourgois and Schonberg 2009), future research may specifically apply the notion of a syndemic to examine how policing interacts with other social phenomena, which work together to exacerbate health conditions. By focusing on synergistic relationships, exploring policing and health through a syndemic lens allows for explicitly making police activity a political endeavor linked to health, rather than a potentially
neutral set of actions done to promote safety. In explicitly politicizing police activities, a syndemic approach may help bring together medical anthropology and the anthropology of policy to critically examine police initiatives and their impacts on health.

A syndemic approach to examining policy and health can further shed light on how notions of trauma and suffering represent relationships in specific moments of time. As Fassin and Rechtman note, trauma is way in which people can represent relationships with the past (Fassin and Rechtman 2009: 15), particularly through collective memories of violence. Future research on immigrant policing should explore the potential for collective memories of police-related trauma and how memories of trauma may manifest in other health-related concerns and be triggered by particular policies or police actions. Furthermore, additional research is need to understand how undocumented immigrants may express needs for policing-related trauma, and how those needs are met. Since undocumented immigrants’ access to health services are precluded in part by discourses of undeservingness, asserting rights to care for police-related trauma may require activist approaches in which immigrants draw from their experiences of suffering to demand rights and entitlements in ways other groups have used their biology (in this case a suffering body that shows signs of trauma) to make demands upon governments (Petryna 2004). If assertions for recognizing police-related trauma occur, this research may benefit future activist efforts as it provides an account of how some undocumented immigrants’ felt traumatized by police activities.

**Reflection on Health-Related Engaged Research**

In considering future engaged scholarship and advocating for immigrants’ rights broadly and immigrants’ rights to health more specifically, I recognize the need to reflect on my theoretical lens and worldview that informed this research and the conclusions I have drawn. As
a medical anthropologist earning a degree in public health while pursuing a PhD in anthropology, I find myself advocating access to biomedicine for populations with limited avenues to care, such as undocumented immigrants. I do so with critical reflection, however, recognizing that biomedicine and public health are technologies of governance, and public health, in particular, captures the essential measures of biopolitics, such as birth rates, death rates, and other essential statistics allowing for greater manipulation and intervention upon bodies (Lock and Nguyen 2010: 24-25). As a profession, public health is part of governing populations by managing vitality through promoting a “healthy” lifestyle (Foucault 1991; Lock and Nguyen 2010: 24), imbuing the body with political objectives and rendering it more available for manipulation by other disciplines, such as biomedicine.

Despite the role of public health and biomedicine in promoting forms of governance, in market-based medical systems limited access to health services is a source of inequality that can result in suffering. As such, I see my role in advocating increased access to health services not serving biomedical hegemony, but rather as part of an effort to challenge inequality and reduce the potential for disproportionate experiences of suffering. This dissertation has been grounded in my commitment to health equity for undocumented immigrants and all marginalized populations, but it has not resulted in greater access to services nor addressed a specific health need. Rather than responding to a specific health concern, my aim in this dissertation has been to draw attention to how immigrant policing is relevant in health research and necessitates activist and researcher attention. Accordingly, a goal for this dissertation is to record and lend legitimacy to stories of suffering from marginalized research participants. For example, when Doña Julia insisted people speak with me, she explained to them that sharing their stories was important so that people knew the kind of suffering immigrants in Atlanta experienced. Recognizing this
perspective, I intend to use findings from this dissertation to lend credibility to the experiences of participants affected by harsh immigration regimes through academic and non-academic publications. Prior to creating any final written products, however, I will share portions of this dissertation with key stakeholders whose insight shaped the reported findings.

Sharing parts of the dissertation with interviewees and fieldwork collaborators serves as a way to validate findings and respond to requested revisions. Furthermore, including participants in data validation processes serves to decolonize the discipline by breaking a researcher-informant boundary and avoids viewing participants as passive “others” without valuable insights (Merry 2005; Speed 2008a). In this respect, sharing chapters and asking for input from interviewees mitigates some of the inherently unequal power dynamics involved in research activities, allowing for participants to have an active role in shaping the final product, rather than being exploited for data collection. Specific chapters of this dissertation will be sent to people featured prominently in them or to people who are exceptionally knowledgeable about the subject matter. Portions of the dissertation will be sent to those listed in table two no later than February 12, 2015, and reviewers will be asked to provide their response by March 12, 2015 (the dissertation defense date). This timeframe will allow the reviewers time to comment on the findings and allow for their comments to be incorporated with other changes to the dissertation. In asking key stakeholders for feedback, I will also initiate conversations about non-academic publications or reports that I can produce from the dissertation to serve specific organizations.

Although I hope to publish academic products from this dissertation, I intend on providing non-academic materials to organizations I worked with to help advance their agendas. This will include a summary on how immigration laws negatively impact immigrants’ health to be provided to the Hispanic Health Coalition of Georgia (HHCGA), GLAHR, and the Clinica for
the Education, Treatment, and Prevention of Addiction (CETPA). Although this research originally aimed to provide policy briefs to be used to advance immigrant rights causes, the ACLU of Georgia has already published policy briefs on how 287(g), Secure Communities, and immigrant policing generally, harms immigrant families. Accordingly, I will offer to write something for the ACLU or edit their existing documents in any way they would find useful. At a national level, I will offer the Immigration Policy Center a report of findings from Georgia and provide it if requested\(^\text{59}\). Lastly, I intend on collaborating with Drs. Angela Stuesse and Mathew Coleman on a policy report for GLAHR that summarizes findings from data collected on GLAHR’s telephone hotline.

In providing non-scholarly work to organizations that assisted with my data collection efforts, I also aim to mitigate some of the unequal power dynamics associated with knowledge production (Speed 2008c). Although other scholars have balanced this dynamic by involving informants in data collection and information dissemination, I view balancing unequal power dynamics between researcher and non-researchers as best done when knowledge produced from research is used in the service of those who occupy marginal social positions and research informants can offer critiques and suggest revisions on the work produced. Moreover, providing non-academic materials can continue the nature of engaged anthropology and activist methods after data collection activities cease since non-academic products can continue to be used in the service of a particular organization or group of people for a period of time that may extend beyond a researcher’s sustained involvement.

\(^{59}\) A staff member at the Immigration Policy Center requested a copy of the dissertation before I started writing, and I will follow up with him once the dissertation is complete.
Recommendations for Policy Directions

Lastly, having documented some of the health related consequences of immigrant policing and grounding this dissertation in part in the anthropology of policy, I draw from findings in this dissertation to suggest future policy directions to mitigate the impacts of immigrant policing. Immigrant rights groups such as GLAHR and the National Day Laborer Organizing Network (NDLON) have advocated ending 287(g) relationships (many of which are ending since the Department of Homeland Security has chosen not to renew agreements in some jurisdictions and will not sign new contracts) (Gomez 2012) and ceasing practices associated with Secure Communities. Similarly, GLAHR and NDLON have rallied for federal immigration reform that would grant amnesty to undocumented immigrants living in the US and include options for family reunification of deported family members (National Day Laborer Organizing Network nd). The Immigration Policy Center has also supported federal amnesty programs as both a humanitarian and economic stimulus effort (The Immigration Policy Center 2013). Recent local and federal policy changes suggest political momentum to advance undocumented immigrants’ rights is growing as GLAHR and Georgia Not1More campaign actions have resulted in sheriffs in some jurisdictions refusing to honor ICE hold requests (Redmon 2014; The Georgia Latino Alliance for Human Rights 2014), and the Secure Communities program has officially been ended (Johnson 2014). The successes may be undermined by new policing efforts, however, especially since a new fingerprint-sharing initiative, the Priority Enforcement Program, will replace Secure Communities (Johnson 2014).

A federal solution to current immigration concerns is therefore necessary and must not reproduce harsh policing regimes already operating. Moreover, reform efforts must be easily

---

60 Amnesty or legalization for all efforts have had increasing social media visibility through the “#11MillionNow!” twitter feed and blogs such as [https://legalizationforall.wordpress.com](https://legalizationforall.wordpress.com).
accessible in that the requirements for changing documentation status are not prohibitively expensive, exclude low-income groups, or immigrants without formal education. Federal solutions must also not be temporary and perpetuate fear and uncertainty, like DACA and DAPA, and be explicitly available to LGBT populations and immigrants without children. Furthermore, federal action is needed to address transnational policies that impact motivations for unauthorized immigration. Several scholars have called for ending the militarization of the US-Mexico border and challenging international agreements that increase demands for transnational labor migration as a result of destabilizing non-US economies (Heyman 2008; Holmes 2013). These suggestions for political action are necessary but lack political traction. Supporting these suggestions but recognizing their difficulty in receiving wide appeal, I suggest smaller policy changes may be needed in the meantime, such as dismantling the way immigrant policing works through increasing undocumented immigrants’ vulnerability through routine traffic enforcement.

Allowing undocumented immigrants to obtain drivers licenses would reduce the number of arrests that can result in potential deportations even if comprehensive immigration reform such as amnesty never comes to fruition. States control their licensing statutes, which makes passing driver’s license laws challenging, however, the federal government could mandate issuing drivers licenses regardless of immigration status by withholding portions of Department of Transportation (DOT) funding unless states complied with the requirements. Withholding DOT funding is within the purview of federal agencies through taxing and spending powers and is how numerous public health measures are justified (Gostin 2008: 101). Through taxing and spending powers, driver’s licenses mandates can be possible, and advocacy organizations should consider this option as a limited source of relief that undermines policing efforts even if it does not fully address the problem. Advocacy organizations must be careful to frame increasing
access to driver’s licenses as an economic concern rather than public health concern, however. Although vehicular safety arguments may advance licensing for all populations through driving examination efforts, vehicular safety rhetoric will reproduce the racially-charged discourses that have historically legitimized immigrants’ differential rights, thus requiring an approach that emphasizes potential revenue through licensing fees.

In addition to recognizing the need for changing policies related to immigrant policing, I also recognize needed changes in specific health policies. The Patient Protection and Affordable Care Act (ACA) continues to exclude undocumented immigrants from health coverage, the effect of which, as Sarah Horton writes, being that “undocumented immigrants will continue to remain dependent upon a fragmented and locally variable health care safety net for their care” (Horton 2014: 314). To address undocumented immigrants’ lack of access to regular, primary health care, Horton suggests providing services and streams of reimbursement for care to undocumented immigrants, explaining that reducing undocumented immigrants’ health disparities is a health equity effort everyone has a stake in (2014: 315). Accordingly, the ACA must be amended to allow for undocumented immigrants to participate in health insurance exchanges. This effort must be advanced as a public health advocacy message of reducing overall health care expenditures and must be done while simultaneously noting undocumented immigrants’ overall lower health service utilization rates when compared to US-born counterparts, complicating messaging. Similarly, emergency Medicaid and public safety-net programs generally require financial commitment to be effective in a market-based medical system. Unless there is political commitment to addressing the failing health safety net, inequalities in care will persist in the US health system and most acutely impact groups such as undocumented ESRD patients who are excluded from primary care and some safety net
programs. As such, efforts to advance undocumented immigrants’ access to health services may be best suited as part of an overall message to reduce health inequalities that persist despite the ACA.

In suggesting these policy directions, my intention is to respond to existing policy and police practices that reinforce racial hierarchies and result in situations immigrants in Atlanta describe as traumatic and fear-inciting, leading them to change health behaviors and daily routines. These suggestions are therefore a set of hopeful recommendations to improve the lives of immigrants who are routinely denied the rights and entitlements of other populations living in the US despite providing countless economic and social contributions.

Figure 23: Outside an Atlanta courthouse after a political demonstration.
REFERENCES

Abraham, Margaret  

Abraido-Lanza, Ana F., Maria T. Chao, and Karen R. Flórez  

Abram, S.  

Abrams, Jamie R.  

Abrams, P.  

Abramsky, Tanya, Charlotte H. Watts, Claudia Garcia-Moreno, Karen Devries, Ligia Kiss, Mary Ellsberg, Henrica A. F. M. Jansen, and Lori Heise  

Abrego, Leisy  

Abu-Lughod, Lila  

Adelman, Madelaine  

Agamben, Giorgio  

Alexander, Michelle  
Alexander, William L.

Alexander, William L., and Magdalena Fernandez

Allen, Brian, Erica M. Cisneros, and Alexandra Tellez

American Nephrology Nurses' Association
2013 Overview: Brief History of Medicare End-Stage Renal Disease (ESRD) Reimbursement.

American Nurses Association

Amit-Talai, Vered

Andrapalli, Vinita

Antecol, Heather, and Kelly Bedard

Arcury, Thomas A., and Sara A Quandt

Arcury, Thomas A., Sara A Quandt, and L. McCauley

Arcury, Thomas A., Sara A. Quandt, Altha J. Cravey, Rebecca C. Elmore, and Gregory B. Russell

Arcury, Thomas A., Sara A. Quandt, and Beverly G. Mellen

Arendt, Hannah

Arnold, C.L.
Aroian, Karen  

Asad, Talal  

Asch, Steven, Barbara Leake, Ronald Anderson, and Lillian Gelberg  

Ashforth, Adam  

Associated Press  
2010 Southeast sees big influx of illegal immigrants.  

Austin, Diane E  

Baba, M. L.  

Baer, Hans A.  

Baker, Daniel, and David Chappelle  

Barajas, R., N. Philipsen, and J. Brooks-Gunn  

Baro, M. and T. Deubel  

Bastide, Roger  

Bates, Reid A.  

Bauder, Harald  
Baumeister, Lisa, and Norman Hearst

Bazylevych, Maryna

Bechtel, Gregory A., Mary Anne Shepherd, and Phyllis W. Rogers

Becker, Gay, Yewoubdar Beyene, and Pauline Ken

Beirich, Heidi, and Southern Poverty Law Center
2011 Georgia Governor Appoints Hate Group Leader to Immigration Board.

Bell, Derrick A, Jr.


Ben-Ari, Eyal

Berk, Marc L., Claudia L. Schur, Leo R. Chavez, and Martin Frankel


Berk, Marc L., Schur, Claudia L., Chavez, Leo R., and Frankel, Martin

Bernauer, James W., and Michael Mahon

Bess, Michael Kirkland
2008 Across imagined boundaries: understanding Mexican migration to Georgia in a transnational and historical context.
Bhabha, Jacqueline

Biehl, João

Blagg, Christopher R.

Blau, Max

Blencowe, Claire

Boal, Augusto

Boehm, Deborah A.

Boonstra, Heather D., and Elizabeth Nash

Bornstein, Robert F.

Bostock, J. A. N., Maureen Plumpton, and Rebekah Pratt

Bourgois, Philippe I., and Jeffrey Schonberg

Braun, J., T. Teklu, and P. Webb

Braun, Lundy
2002  Race, ethnicity, and health: can genetics explain disparities? Perspectives in Biology and Medicine 45(2):159-174.

Bronfenbrenner, Urie

361


Calavita, Kitty

Campbell, G. A., S. Sanoff, and M. H. Rosner

Campbell, Kristina M.

Capps, R., M. Rosenblum, C. Rodriguez, and M. Chishti

Carrion, Iraida V., Heide Castañeda, Dinorah Martinez-Tyson, and Nolan Kline

Cartwright, Elizabeth

Castañeda, Heide
2007 Paradoxes of Providing Aid: NGOs, Medicine, and Undocumented Migration in Berlin, Germany Dissertation, Anthropology, University of Arizona.

—

—

—

—

Castañeda, Heide, Iraida V. Carrion, Nolan Kline, and Dinorah Tyson-Martinez

Castañeda, Heide, Seth M. Holmes, Daniel S. Madrigal, Maria-Elena DeTrinidad Young, Naomi Beyeler, and James Quesada
Castañeda, Heide, Nolan Kline, Mackenzie Rapp, Nicole Demetriou, Naheed Ahmed, Isabella Chan, Theresa Crocker, Nathaniel Dickey, Patrick Dillon, and Hilary Dotson

Castañeda, Heide, and Milena Melo

Castañeda, Heide, and Milena Andrea Melo

Centers for Disease Control and Prevention
2014 National Chronic Kidney Disease Fact Sheet.

Chacón, Jennifer M.

Chang, Grace

Charnley, S., and W.H. Durham

Chaudry, Ajay, Randy Capps, Juan Manuel Pedroza, Rosa Maria Castaneda, Robert Santos, and Molly M. Scott

Chavez, L.R.

Chavez, Leo R.


Checker, Melissa

Chin, Gabriel J., and Marc L. Miller

Clark, A. Kim

Clark, Brietta R.
Cleaveland, Carol, and Emily S. Ihara  

Clemans-Cope, Lisa, Genevieve M. Kenney, Matthew Buettgens, Caitlin Carroll, and Fredric Blavin  
2012 The Affordable Care Act’s coverage expansions will reduce differences in uninsurance rates by race and ethnicity. Health Affairs 31(5):920-930.

Clifford, James  

Coburn, David  

Cole, Alexandra  
2012 Prisoners of Profit: Immigrants and Detention Georgia. American Civil Liberties Union of Georgia.

Coleman, M.  

Coleman, Mathew  

—  
2012 The "Local" Migration State: The Site-Specific Devolution of Immigration Enforcement in the US South. Law & Policy.

Coleman, Mathew, and K. Grove  

Coleman, Mathew, and Austin Kocher  

Coleman, Mathew, and Angela Stuesse  

Colino, Stacey  

Collins, Patricia  

Collins, Patricia Hill  
Comaroff, Jean, and John Comaroff  
2000 Millennial Capitalism: First Thoughts on a Second Coming. Public Culture  

Conley, Dalton  

Constantinou, Costas S.  
2012 “Now, I Am a Proper Human Being”: Kidney Transplantation in Cyprus. Medical  

Conyers, John  

Correia, Mark E.  
2010 Determinants of attitudes toward police of Latino immigrants and non-immigrants.  

Coughlin, Teresa A.  
1997 The Medicaid disproportionate share hospital payment program: Background and  
issues.

Coutin, Susan Bibler  
2003 Legalizing moves: Salvadoran immigrants' struggle for US residency. Ann Arbor:  
University of Michigan Press.

——  

——  

——  
2010 Confined within: National territories as zones of confinement. Political  

Crawford, Tom  
2013 Nursing licenses held up by immigration law, Vol. 2014.

Crenshaw, Kimberlé  
1991 Mapping the margins: Intersectionality, identity politics, and violence against  

Crenshaw, Kimberlé  
1995 Mapping the Margins: Intersectionality, Idenity, Politics, and Violence Against  
Women of Color. In Critical Race Theory: The Key Writings that Formed the Movement.  

Crenshaw, Kimberlé, Neil Gotanda, Gary Peller, and Kendall Thomas  

Das, Veena  
2007 Life and Words: Violence and the Descent into the Ordinary: Univ of California  
Press.
David, Richard J., and James W. Collins

David, Richard, and Jr. James Collins

Davis, Dana-ain

Davis, Joffe

Davis, Karyl Alice
2004 Unlocking the Door by Giving Her the Key: A Comment on the Adequacy of the U-Visa as a Remedy. Ala. L. Rev. 56:557.

De Genova, N.
2004 The Legal Production of Mexican/Migrant "Illegality". Latino Studies 2(2):160-185.

De Genova, Nicholas

De Genova, Nicholas P.

De Genova, Nicholas P.

De Waal, A., and A. Whiteside

Delgado, Richard

Delgado, Richard, and Jean Stefancic

Denzin, Norman

Deubel, Tara

Dewan, Shaila, and Kevin Sack
Doty, Roxanne Lynn

Dowling, Julie, and Jonathan Inda

Dreby, Joanna
2012 How today’s immigration enforcement policies impact children, families, and communities: A view from the ground.

Ecks, D.S.

Ellsberg, Mary, Henrica A. F. M. Jansen, Lori Heise, Charlotte H. Watts, and Claudia Garcia-Moreno

Ellwood, Marilyn R., and Leighton Ku

Elmore, R. C., and T. A. Arcury

Erez, Edna, Madelaine Adelman, and Carol Gregory

Ervin, A. M., and A. Mackay

Escobar, A.

Escobar, Javier I., Hoyos Nervi Constanza, and Michael A. Gara
2009 Immigration and Mental Health: Mexican Americans in the United States.

Euskirchen, Markus, Henrik Lebuhn, and Gene Ray

Faigin, David, and Catherine Stein
2010 The power of theater to promote individual recovery and social change. Psychiatric services 61(3):306-308.

Fairchild, Amy L.
Farmer, Frank L., and Doris P. Slesinger

Farmer, Paul


Fassin, Didier


— 2009 Another politics of life is possible. Theory, Culture & Society 26(5):44.

Fassin, Didier, and Richard Rechtman
2009 The Empire of Trauma: An Inquiry into the Condition of Victimhood: Princeton University Press.

Fassin, Didier, and Paula Vasquez

Fee, Alison
1998 Forbidding states from providing essential social services to illegal immigrants: the constitutionality of recent federal action. BU Pub. Int. LJ 7:93.

Fiscella, Keven, Peter Franks, Mark P. Doescher, and Barry G. Saver

Foley, Elise
2014 Georgia Republicans Aim To Keep Driver's Licenses From Dreamers. Huffington Post.

For the Journal-Constitution

Foucault, M.
2002 Archaeology of knowledge: Psychology Press.

Foucault, Michel


2003 Society must be defended: lectures at the Collège de France, 1975-76: Picador USA.

Fragomen, Austin T.


Frank, Richard G., Thomas G. McGuire, and Joseph P. Newhouse


Freeman, Alan David


Friends of Stacey Y. Abrams


Fujiwara, Lynn H.


Galea, Sandro, Melissa Tracy, Katherine J. Hoggatt, Charles DiMaggio, and Adam Karpati


Gamble, Molly


García, Angela S.


Gardner, D. B.


Georgia Restaurant Association

No Year Join Us in Opposing Costly Immigration Bills (HB-87/SB-40).
Giles, Howard, Daniel Linz, Doug Bonilla, and Michelle Leah Gomez  

Gillespie, S.  

—  

Goffman, Erving  

Golendale, Kathryn  

Goldman, D. P., J. P. Smith, and N. Sood  

—  

Gomez, Alan  
2012  Immigration enforcement program to be shut down.  

Gonzales, Roberto G., Veronica Terriquez, and Stephen P. Ruszczyk  

Gordon, Edmund T  

Gordon, Elisa J.  

Gordon, Ian, and Tasneem Raja  

Gostin, Lawrence O.  

Gottlieb, N., D. File, and N. Davidovitch  

Grady Health System  

—  
Green, Linda
Greenberg, David F.
Greene, H. R.
Greenwood, Gregory L., Michael V. Relf, Bu Huang, Lance M. Pollack, Jesse A. Canchola, and Joseph A. Catania
Grillo, Jery
Grossman, Daniel, Sarah Baum, Liza Fuentes, Kari White, Kristine Hopkins, Amanda Stevenson, and Joseph E. Potter
2014 Change in abortion services after implementation of a restrictive law in Texas. Contraception.
Gupta, Dipankar
Gusterson, H.
Gwyther, Marni E., and Melinda Jenkins
Hacker, Karen, Jocelyn Chu, Lisa Arsenault, and Robert P. Marlin
Hacker, Karen, Jocelyn Chu, Carolyn Leung, Robert Marra, Alex Pirie, Mohamed Brahimi, Margaret English, Joshua Beckmann, Dolores Acevedo-Garcia, and Robert P. Marlin
Haenn, Nora, and David G. Casagrande
Hagan, Jacqueline, Nestor Rodriguez, Randy Capps, and Nika Kabiri
Hale, C. R.

Hale, C.R.
2007 In Praise of "Reckless Minds". Anthropology put to work:103.

Hale, Charles R.


Hall, Julia

Halperin, Diana

Hamdy, Sherine

Hamdy, Sherine F.

— 2013 Political Challenges to Biomedical Universalism: Kidney-Failure among Egypt’s Poor. Medical Anthropology (just-accepted).

Hannerz, Ulf

Hardy, Lisa J., Christina M. Getrich, Julio C. Quezada, Amanda Guay, Raymond J. Michalowski, and Eric Henley

Harvey, David
2007 A Brief History of Neoliberalism: Oxford University Press.

Heath, D., R. Rapp, and K.S. Taussig

Heckathorn, Douglas D.

Heidbrink, Lauren
Hellerstein, Erica
2014 The Rise of the DIY Abortion in Texas.

Heyman, J. M. C., G. G. Núñez, and V. Talavera

Heyman, J. M. C.

Heyman, J. M. C., M. C. Morales, and G. G. Nuñez

Heyman, Josiah
http://accessdeniedblog.wordpress.com/2009/12/01/you-lie-going-beyond-the-obama-wilson-debate/.

Heyman, Josiah McC, Guillermina Gina Núñez, and Victor Talavera

Heyman, Josiah McC.

Hiemstra, Nancy

Himmelgreen, David A., Rafael Pérez-Escamilla, Dinorah Martinez, Ann Bretnall, Brian Eells, Yukuei Peng, and Angela Bermúdez

Himmelgreen, David, Nancy Romero Daza, Elizabeth Cooper, and Dinorah Martinez

Ho, Karen

Hoerster, Katherine D., Sandra Beddawi, K. Michael Peddecord, and Guadalupe X. Ayala

Hoffman, Beatrix
Holmes, Seth
2013 Fresh fruit, broken bodies: Migrant farmworkers in the United States: University of California Press.

Holmes, Seth M.

hooks, bell

Horton, Sarah

—

—

Horton, Sarah, Cesar Abadia, Jessica Mulligan, and Jennifer Jo Thompson

Horton, Sarah B., and Judith C. Barker

Horton, Sarah, and Judith C. Barker

Horton, Sarah, and Analisia Stewart

Howard, Kirsten, Glenn Salkeld, Sarah White, Stephen McDonald, Steve Chadban, Jonathan C. Craig, and Alan Cass

Howard, Leigh Anne

Hsia, Renee Y., Arthur L. Kellermann, and Yu-Chu Shen
Hsieh, Hui-Min, and Gloria J. Bazzoli  

Huang, Priscilla  

Huang, Z.J., M.Y. Stella, and R. Ledsky  

Human Impact Partners  

Human Rights Watch  

Huschke, Susann  

Hyatt, Susan Brinn  

Hymes, Dell  

Inda, Jonathan Xavier  

Inda, Jonathan Xavier, and Julie A. Dowling  

Isin, Engin F., and Bryan S. Turner  

Janoski, Thomas, and Brian Gran  

Jessop, Bob  

Jewkes, Rachel  

Johnson, Jeh Charles  
Johnson, Kevin R.

Joyce, Theodore

Juris, Jeffrey, and Alex Khasnabish

Kaiser Commission on Facts
2006 Medicaid and SCHIP Eligibility for Immigrants: The Henry J. Kaiser Family Foundation.

Kiefer, Christine W.

Kipnis, A.
Kipnis, A.B.  

Kline, Nolan  
2010a The Aggregated Influences of Poverty Impacting Dental Care Access and Oral Health among Migrant Farmworkers in Tampa, Florida, Anthropology, University of South Florida.


Kline, Nolan, and Rachel Newcomb  

Kobach, Kris W.  

Koch, Erin  

Kretsedemas, Philip, and Davi C. Brotherton  

Ku, L., and S. Matani  


Ku, Leighton  

Ku, Leighton, and Fouad Pervez  

Kuck, Charles  

Kullgren, J.T.  
Lamphere, Louise

Larchanché, S.

LaRocco, Susan

Lee, Tiana Mayere

Leerkes, Arjen, Mark Leach, and James Bachmeier

Lem, Winnie, and Belinda Leach

Leventhal, T., and J. Brooks-Gunn

Levine, Rhonda F.

Lewis, Diane

Liebert, Saltanat, and Carl F. Ameringer

Linehan, Kathryn

Linthicum, Kate
Lister, Ruth

Livingston, Gretchen

Lock, Margaret

Lock, Margaret, and Vinh-Kim Nguyen

Lopes, Harrison
2014 The relationships between permissive and restrictive state immigration laws and violent crime rates in big cities, GEORGETOWN UNIVERSITY.

Lora, Claudia M., Martha L. Daviglus, John W. Kusek, Anna Porter, Ana C. Ricardo, Alan S. Go, and James P. Lash

Luibhéid, E.

Lukes, Sherri M., and Bret Simon

Maira, Sunaina

Maldonado, Cynthia Z., Robert M. Rodriguez, Jesus R. Torres, Yvette S. Flores, and Luis M. Lovato

Manley, Harold J., Cory G. Garvin, Debra K. Drayer, Gerald M. Reid, Walter L. Bender, Timothy K. Neufeld, Sudarshan Hebbar, and Richard S. Muther

Mann, Lilli, Florence M. Simán, Mario Downs, Jorge Alonzo, PhD Eun-Young Song, JD Mark Hall, and PhD Scott D. Rhodes, MPH, CHES

Marcus, G.E., and M.M.J. Fischer
Marcus, George E.

Marmon, Theodore R., and Jonathan Oberlander

Marrow, Hellen B.

Martin, Jack

Martin, James

Martinez, Daniel, and Jeremy Slack

Maskovsky, J.
2005 Do People Fail Drugs, or Do Drugs Fail People?: The Discourse of Adherence. Transforming Anthropology 13(2):136-142.

Maskovsky, Jeff

Maskovsky, Jeff, and Catherine Kingfisher

Massey, Douglas S., and Karen A. Pren

Maternowska, M. C.
2006 Reproducing inequities: Poverty and the politics of population in Haiti: Rutgers Univ Pr %@ 0813538548.

McDonald, R. Robin
2014 Hospital, Medical Firm CEOs to Plead Guilty to Kickbacks. Read more: http://www.dailyreportonline.com/id=1202665296890/Hospital-Medical-Firm-CEOs-to-Plead-Guilty-to-Kickbacks - ixzz3OwpXYwZg, accessed January 12, 2015.

McEwen, Bruce S.

McGillivray, Anne, and Brenda Comaskey
1999 Black eyes all of the time: Intimate violence, aboriginal women, and the justice system: University of Toronto Press.
McGuire, Sharon, and Jane Georges

McWhorter, Ladelle


Mechanic, Robert

Meier-Kriesche, Herwig-Ulf, and Bruce Kaplan

Menjívar, Cecilia

Menjívar, Cecilia, and Cynthia Bejarano

Menjívar, Cecilia, and Olivia Salcido

Merry, Sally Engle


Migration Policy Institute

Miller, Andy


Miller, Andy, and Teresa Borden  

Miller, Daniel, and Don Slater  

Miller, Joel, and Robert C. Davis  

Miller, Kenneth E., and Andrew Rasmussen  
2010  War exposure, daily stressors, and mental health in conflict and post-conflict settings: bridging the divide between trauma-focused and psychosocial frameworks. Social Science & Medicine 70(1):7-16.

Miller, T.A.  
2005  Blurring the boundaries between immigration and crime control after September 11th. BC Third World LJ 25:81.

Miller, Teresa A.  

Minn, Pierre  

Mishtal, Joanna Z.  

Moberg, Mark  

Modi, Monica N., Sheallah Palmer, and Alicia Armstrong  

Mohanty, S.A., S. Woolhandler, D.U. Himmelstein, S. Pati, O. Carrasquillo, and D.H. Bor  

Mor, Vincent, Jacqueline Zinn, Joseph Angelelli, Joan M. Teno, and Susan C. Miller  

Morgen, Sandra, and Jeff Maskovsky  

Morris News Service  
Mott, Lawrie
Mountz, Alison, Richard Wright, Ines Miyares, and Adrian J. Bailey
Muennig, Peter, and Marianne C. Fahs
Nader, Laura


National Day Laborer Organizing Network
nd  Legalization, Vol. 2014.
National Kidney and Urologic Diseases Information Clearinghouse
National Vital Statistics Reports
Naylor, C. David
Neubeck, Kenneth J., and Noel A. Cazenave
Ngai, Mae M.
Nguyen, V.K.
Nguyen, Vinh-Kim
O'Connor, Alice
O'Daniel, A. A.
O'Leary, Anna Ochoa, and Azucena Sanchez
Oberlander, Jonathan B., and Barbara Lyons

Odem, Mary

Office of Management and the Budget

Okie, Susan

Olsson, Tore C
2014 Latino Immigration In New Georgia Encyclopedia.

Ong, A.

Ong, Aihwa


Ong, Marcos, and David A. Jenks

2007 Health care access, use of services, and experiences among undocumented Mexicans and other Latinos. Archives of Internal Medicine 167(21):2354.

Ortner, Sherry

Ortner, Sherry B.

Paluska, Mike

Park, Madison
Parker, Katy
No Year Local Enforcement of Immigration - Secure Communities & 287(g)
American Civil Liberties Union of North Carolina.
Parson, Nia, Rebecca Escobar, Mariam Merced, and Anna Trautwein
2014 Health at the intersections of precarious documentation status and gender-based
partner violence. Violence against women:1077801214545023.
Passel, Jeffrey S., D'vera Cohn, and Anna Gonzalez-Barrera
2013 Pew Researcher Center: Population Decline of Unauthorized Immigrants Stalls,
May Have Reversed.
Patten, Eileen, and Jeffrey S. Passel
2014 How Obama’s executive action will impact immigrants, by birth country.
http://www.pewresearch.org/fact-tank/2014/11/21/how-obamas-executive-action-will-
Patterson, Thomas C.
Perdue, Sonny, and State of Georgia
2005 Medicaid Modernization for a New Georgia: Section 1115a Waiver.
Perea, Juan F.
1997 Immigrants out!: the new nativism and the anti-immigrant impulse in the United
States: NYU Press.
Pérez-Escamilla, Rafael, Jonathan Garcia, and David Song
2010 Health care access among Hispanic immigrants: ¿ Alguien está escuchando?[Is
Petryna, A.
—
2004 Biological citizenship: The science and politics of Chernobyl-exposed populations.
Osiris 19:250-265.
Pew Hispanic Center
Phillips, Jerica
2012 Controversial immigration law moving through Miss. legislature.
moving-through-miss-legislature.
Pierson, P
1996 Dismantling the Welfare State? Reagan, Thatcher, and the Politics of
Retrenchment. Cambridge: Cambridge University Press.
Pizzi, Richard
2009 Atlanta hospital may limit access to free care.
Plichta, Stacey B.
2004 Intimate partner violence and physical health consequences policy and practice
Posner, Karen L., William M. Gild, and Edgar V. Winans  

Poster, Mark  

Poulantzas, Nicos  
1973  Political power and social classes. T. O'Hagan, transl. London: NLB.

Pourat, Nadereh, Steven P. Wallace, Max W. Hadler, and Ninez Ponce  

Powell, Benjamin  

Pulido, Laura  

—  

Quandt, Sara A., Heather M. Clark, Pamela Rao, and Thomas A. Arcury  

Raj, Anita, Jay G. Silverman, Jennifer McCleary-Sills, and Rosalyn Liu  

Rasmussen, Kim Su  

Redfield, Peter  

Redmon, Jeremy  
2012  Nearly 600 government agencies face penalties under immigration law.  

—  
2014  DeKalb jail won’t comply with ICE detainers under certain conditions.  

Restrepo, Eduardo, and Arturo Escobar  
Rhodes, Rosamond  

Rizzo, Salvador  

Robbins, Joel  

Robert W. Woodruff Foundation  

Roberts, Dorothy  

Roberts, Dorothy E.  
—  
—  
2011  Killing the black body: Race, reproduction, and the meaning of liberty.  

Rodriguez, Marc Lacey and Salvador  

Rodriguez, Michael, Jeanette M. Valentine, John B. Son, and Marjani Muhammad  

Rosas, Gilberto  

Rose, Nikolas  
—  
—  

Rose, Nikolas, and Carlos Novas  
Roseberry, William

Rosenthal, Anat

Rousseau, C., S. Ter Kuile, M. Munoz, L. Nadeau, M. J. Ouimet, L. Kirmayer, and F. Crepeau

Ruiz-Casares, Monica, Cecile Rousseau, Ilse Derluyn, Charles Watters, Francois Crepeau, and education Department of Special

Rylko-Bauer, Barbara, and Paul Farmer

Rylko-Bauer, Barbara, Merrill Singer, and John Van Willigen

Sack, Kevin


2011  Clinic Rejects Immigrants After Impasse With Hospital. 

Sack, Kevin, and Shaila Dewan
2007  Atlanta Hospital Moves to Unburden Itself of Debt. 

Sack, Kevin, and Catrin Einhorn
2010  Deal Would Provide Dialysis to Illegal Immigrants in Atlanta 

Sacks, Mike
2012  Arizona Immigration Law's Supreme Court Oral Argument Set For April. 
http://www.huffingtonpost.com/2012/02/03/arizona-immigration-law-_n_1253502.html.

Sáenz, Rogelio, Cecilia Menjívar, and San Juanita Edilia Garcia

Sainsbury, Diane

Salcido, Olivia, and Madelaine Adelman

Saldaña, Johnny

Sanders, Michael

Sanford, Victoria

Sanjek, Roger

Sargent, C., and S. Larchanchché

Sassen, Saskia

Schepers-Hughes, Nancy


Schneider, Craig

Schneider, J. A.

Schwegler, T.A.

Sen, A.
1999   Development as freedom: Oxford University Press %@ 0198297580.

Serrano, Alfonso

Shahshahani, Azadeh
2009   Terror and Isolation in Cobb: How Unchecked Police Power under 287 (g) has Torn Families Apart and Threatened Public Safety. American Civil Liberties Union.

Shapiro, Thomas M.

Sheikh, Irum

Sheth, Falguni A
2009   Toward a Political Philosophy of Race. Albany: SUNY Press.

Shever, E.

Shimazono, Yosuke
Shore, C., and S. Wright

Silove, Derrick, Zachary Steel, and Richard F. Mollica

Silva, E.

Singer, M.

Singer, M., F. Valentin, H. Baer, and Z. Jia

Singer, Merrill


Singer, Merrill, Hans A. Baer, and Ellen Lazarus

Singer, Merrill, and Arachu Castro

Singh, Shefali

Skogan, Wesley G., and Susan M. Hartnett

Skogan, Wesley G., Lynn Steiner, Jill Dubois, J. Erik Gudell, and Aimee Fagan
2002 Taking stock: Community policing in Chicago: US Department of Justice, Office of Justice Programs, National Institute of Justice.
Slack, Jeremy, Daniel Martinez, and Scott Whiteford  
2013  In the Shadow of the Wall: Family Separation, Immigration Enforcement and Security. Preliminary Data from the Migrant Border Crossing Study.

Smith, Anna Marie  
2010a  Neo-eugenics: A Feminist Critique of Agamben.  

Smith, Jennifer M.  

Sommers, Benjamin D.  

Speed, Shannon  

—  

—  

—  

State of Georgia  
2005  Governor Perdue Announces Strict Documentation Requirement for Medicaid Registration.

Stith, Sandra M., Douglas B. Smith, Carrie E. Penn, David B. Ward, and Dari Tritt  

Stoler, Ann Laura  

Strathern, Marilyn  

Stuesse, A. C.  
2008  Globalization “Southern Style”: Transnational Migration, the Poultry Industry, and Implications for Organizing Workers across Difference Dissertation, Anthropology, University of Texas, Austin.

Stuesse, Angela C.  


The United States Department of Justice 2014 Government Intervenes in Lawsuit Against Tenet Healthcare Corp. and Georgia Hospital Owned by Health Management Associates Inc. Alleging Payment of Kickbacks.


Tjaden, Patricia Godeke, and Nancy Thoennes 2000a Extent, nature, and consequences of intimate partner violence. US Department of Justice, Office of Justice Programs, National Institute of Justice Washington, DC.

Tjaden, Patricia, and Nancy Thoennes 2000b Prevalence and consequences of male-to-female and female-to-male intimate partner violence as measured by the National Violence Against Women Survey. Violence against women 6(2):142-161.

Traweek, Sharon 2009 Beamtimes and lifetimes: The world of high energy physicists: Harvard University Press.
Treaster, Cyndi, Suzanne R. Hawley, Angelia M. Paschal, Craig A. Molgaard, and Theresa St Romain

Trevizo, Perla

—

—

Tyler, Imogen

U.S. Census Bureau

—

U.S. Citizenship and Immigration Services

U.S. Renal Data System

Uggen, Christopher, and Jeff Manza

United States Citizenship and Immigration Services
2013 USCIS Approves 10,000 U Visas for 5th Straight Fiscal Year.

United States Congress

United States Department of Health and Human Services

US Department of Homeland Security: Immigration and Customs Enforcement
No Date Fact Sheet: Delegation of Immigration Authority Section 287(g) Immigration and Nationality Act, Vol. 2014.
US Immigration and Customs Enforcement


Valdez, Carmen R., Brian Padilla, and Jessa Lewis Valentine


Viladrich, A.


Viruell-Fuentes, Edna A.


Wacquant, Loic


Wacquant, Loïc


Wailoo, Keith, and Julie Livingston


Wailoo, Keith, Julie Livingston, and Peter Guarnaccia


Walcott, Susan M., and Arthur Murphy


Walker, Kyle E., and Helga Leitner


Ward, Louise S.


Warner, David C.

Warren, Kay B

Warry, W.

Weathers, Andrea, Cynthia Minkovitz, Patricia O’Campo, and Marie Diener-West

Weaver, Christopher
2014 Justice Department to Join Suit Against Tenet Healthcare, Health Management Associates.

Weaver, T.

Websdale, Neil

Wedel, J. R., C. Shore, G. Feldman, and S. Lathrop

Wedel, Janine. R.
2001 Collision and collusion: The strange case of Western aid to eastern Europe. New York: Palgrave.

Wells, M.J.

Wernick, Laura J., Alex Kulick, and Michael R. Woodford

Wessler, Seth Freed
2011a Georgia Immigrant Couple Fights to Regain Custody of Kids.


West, Carolyn M.

Wies, Jennifer R.
Willen, Sarah S.
— 2011a Do "Illegal" Im/migrants Have a Right to Health? Engaging Ethical Theory as Social Practice at a Tel Aviv Open Clinic. Medical Anthropology Quarterly 25(3):303-330.
Willen, Sarah S.
2011b How is health-related" deservingness" reckoned? Perspectives from unauthorized im/migrants in Tel Aviv. Social Science & Medicine.
Willen, Sarah S., Jessica Mulligan, and Heide Castañeda
Willging, Cathleen E., Howard Waitzkin, and Ethel Niedao
2008 Medicaid managed care for mental health services: The survival of safety net institutions in rural settings. Qualitative Health Research 18(9):1231-1246.
Williams, Misty
2011a Dialysis treatments discontinued. The Atlanta Journal-Constitution, September 2.
Wilson, Astrid Hellier, Judith Lupo Wold, Lorine Spencer, and Kathleen Pittman
Winders, J.
Winders, Jaime

Wolf, Eric R.


Wong, Jessica, and David Mellor

Woodson, D.G.

Woolhouse, Megan
2004 Hospital stops issuing long-used 'Grady Card'.

Wynn, Barbara, Theresa Coughlin, Serhiy Bondarenko, and Brian Bruen
2002 Analysis of the Joint Distribution of Disproportionate Share Hospital Payments. PM-1387-ASPE. RAND and the Urban Institute.


Yarbrough, Robert A.

Yarris, Kristin, and Heide Castañeda
Forthcoming Introduction: Ethnographic Insights on Displacement, Migration, and Deservingness in Contemporary Global Contexts. International Migration.

Yelvington, Kevin

Yoo, Grace J.

Young, Allan

Zayas, Luis H., and Mollie H. Bradlee
Zuckerman, Stephen, Timothy A. Waidmann, and Emily Lawton
2011 Undocumented immigrants, left out of health reform, likely to continue to grow as share of the uninsured. Health Affairs 30(10):1997-2004.