

Episode: Ethics Talk - Refugee Care and Border Abolition

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TIM HOFF: [mellow theme music] Welcome to another special edition of *Ethics Talk*, the *American Medical Association Journal of Ethics* podcast on ethics in health and health care. I'm your host, Tim Hoff. Joining us today is Dr Hannah Janeway, an International and Domestic Health Equity and Leadership Fellow at the University of California, Los Angeles. Dr Janeway also works with the Refugee Health Alliance, a nonprofit organization that provides health care and addresses social determinants of health for asylum seekers at the US-Mexico border in Tijuana. They're with us to discuss the ongoing humanitarian crises at the U.S. southern border and how the way we think about borders informs how we see what the people crossing them deserve from us. Dr Janeway, thank you for joining me.

DR HANNAH JANEWAY: Yeah, of course.

HOFF: Despite media focus on election matters and the pandemic, we can't forget about the ongoing humanitarian and health crises at the U.S. southern border. So, to begin with, can you tell our listeners about the current conditions around the border and for those in detention, and how your work with the Refugee Health Alliance fits into the landscape of what's happening?

JANEWAY: Yeah, of course. So, conditions for migrants at the border and in border cities has never been great. Many of these cities are listed as some of the most violent cities in the world. For instance, Tijuana, I think is the most dangerous city in the world for violent crime per capita. And the public health system to begin with, at its baseline, is incredibly stressed by the needs of the Mexican population. So, prior to COVID-19 we had significant issues finding specialty care or higher level of care services for our patients. And many times, they received what I would consider to be suboptimal care in local hospitals or were just completely turned away.

Since the beginning of COVID-19, the only public hospital in Tijuana, for instance, Tijuana General is itself closed completely to only COVID-19 patients, which means that there is no public hospital currently in Tijuana where people can go and get care if they do not have health insurance or money. The only two public hospitals that are currently serving our patient population are at least 30 to 45 minutes away from the center of Tijuana and are Rosarito General Tecate General. So, we have actually been struggling most recently with a resurgence of the COVID-19 pandemic. And so, even the hospitals like Rosarito General and Tecate General are completely full, and many times our patients will arrive at a hospital. For instance, we had a patient who had an obstetric emergency, and she was turned away from the hospital because the hospital claimed that they didn't have an anesthesiologist or a surgeon on duty and literally gave her no option for where to go. So, that's the current situation that we're dealing with at the Border.

Refugee Health Alliance started in 2018. It began in response to the increasing number of migrants at the U.S.-Mexico border. And at first, we were just kind of a loose coalition of health care providers, students, concerned citizens from the United States and Mexico

going to different shelters and trying to provide medical care to these larger-than-normal caravans that were arriving. Since that time, we became a formal nonprofit, and we now run two clinics, one that's called Justicia en Salud—which is a midwifery, prenatal, and naturopathic medical clinic that's run by local midwives, most of whom are Indigenous midwives—and Resistencia en Salud, which is a general medical and pediatric clinic. We also provide telemedicine services and in-person care to over 30 shelters in Tijuana and have prioritized things like LGBTQ care, which we see as fundamental, a fundamental human right, and do gender affirmation as part of the basic medical care that we provide. We also have a mental health team that works with local psychologists and the local university. We have a medical legal team that does independent evaluations for humanitarian parole and forensic evaluations.

We work to bring basic determinants of health to people, including food, housing resources, things like building handwashing stations for basic hygiene. And then we recently just opened one of two public water fountains in Tijuana. They were the first of their kind to ever exist, as far as I can tell, in Tijuana itself. So, Refugee Health Alliance actually does a lot of different things. And our basic motto is to provide kind of borderless medicine so that people have access to care no matter what side they are of the border they're on.

HOFF: Great. Thank you. I imagine the recent extreme weather in Texas has exacerbated some of the conditions along the border and in detention facilities. Can you speak a little bit to what you're seeing in the recent week or so?

JANEWAY: Yeah. So, we're lucky in Tijuana that many individuals seeking asylum are living in actual shelters, although those shelters aren't heated, and that, at times, can be really problematic, especially in the winter. But right now, in Matamoros, for instance, where there's this huge crisis because there's snow and rain and sleet and it's freezing cold, most of the migrants who are in Matamoros are in tents outside exposed to all these elements. It's a complete disaster. And really it's one that's on us because the majority of the migrants who are in Tijuana right now are asylum seekers under the MPP program, which was a program that many people know as the Remain in Mexico program, that basically sent asylum seekers back to Mexico instead of allowing them to await their court hearings and asylum hearings in the United States, which is, as far as I can tell, against most international law. So, now we have this total crisis where there are thousands of people in Matamoros who are potentially freezing to death because of the conditions. And it's really, really devastating, I think, because it was completely preventable.

HOFF: The process of forcing asylum seekers to wait outside of the U.S. while their cases are adjudicated is also just not historically how the U.S. has responded to asylum seekers. Can you help our listeners understand the contrast between the U.S. legal responses to asylum seekers then and now, and how they're changing and how legal responses influence how migrants' health and human needs are met?

JANEWAY: Yeah, absolutely. So, MPP or the Migrant Protection Protocols, also known as the Remain in Mexico policy, has had real significant legal implications for asylum seekers, I think the largest of which is the lack of legal support for individuals in that program. If you think about it, people prior to MPP were generally dispersed around the country to the area where they had their sponsors, usually family members, but sometimes individuals who sponsor asylum seekers. And when this stopped happening because they sent everyone back to Mexico, it consolidated the legal burden to one area. So, for instance, for us, it consolidated all the legal cases and all the asylum seekers to San Diego. And there's

simply not enough pro bono immigration lawyers to take all of these cases. So, therefore, many of these individuals were forced to represent themselves with support from this really amazing organization called Al Otro Lado in San Diego. But, you know, even with the advice and support of that group, it's extremely difficult to represent yourself in court for asylum case when you don't speak the language. And in addition, because asylum cases are very complicated cases, and they're very difficult to actually win.

So, I think that is the most devastating consequence. And that has played out. If you look at the statistics, it's less than 10 percent of those people are winning their asylum cases, which is a lot less than normal if you look at the figures that were before the MPP program was begun.

HOFF: Hmm.

JANEWAY: You have to add into this the fact that many of these people were forced then to stay in Tijuana or stay in Matamoros or in Mexicali, wherever they were sent back. And as I was speaking about before, these are incredibly dangerous cities. Many of our patients have faced threats and violence from the people who were after them in their own home countries, people they were fleeing from. There's alliances between different cartels. There's been just so many kidnappings assaults. We've had patients be murdered. And so, they're being sent back to Tijuana where they don't have access to adequate health care, they don't have access to adequate housing, and they're in these highly unsafe environments. And these are incredibly traumatized individuals who are already fleeing violence. So, it's had an incredible consequence on people's mental health and on people's physical health, which is really unfortunate.

Yesterday, I actually had the great privilege to, as part of Refugee Health Alliance, to work with IOM and UNHRC at the first day of screenings for individuals under MPP to cross the border. This is in response to Biden saying that he is doing away with MPP, which is a thing that I applaud. And we did the medical screenings and provided people with medications who are going to be crossing the border into California. Which was actually the first spot in the United States to have people cross after the MPP program was, you know, as part of this dismantling of the MPP program.

However, even though all these people from MPP are now able to cross, I think it was 25,000 people, there are still so many other people who are at the border who have been waiting for years on these lists from the illegal metering program that the Trump administration put into place. But still, we still haven't heard anything from the Biden administration about those individuals. There's a lot of people who have arrived at the border since the borders closed and who are not even on those lists. There are a lot of people who lost their cases very unfairly as part of the MPP. They showed up, tried to show up for court, but weren't allowed to go, and then their cases were dropped or dismissed. And so, there's just so many other people who are still stuck in these border cities. And the new administration has yet to announce policies to how to deal with those asylum seekers and how to do things fairly and in the best interests of health for all.

HOFF: So, how does the way that we think about the political or maybe even geographic nature of borders inform how we see what people crossing them, be they refugees or asylum seekers or people crossing for any reason, really, how we see what they deserve from us as either individual citizens or from our government or from, in your case, medical professionals?

JANEWAY: Yeah. So, Refugee Health Alliance's mission to have borderless medicine, I think, is part of the larger movement for border abolition. I think as a health care provider, my work at the border has really forced me to think about important questions about what borders mean, how they were formed, and who should have access to each side of the border. Asylum is a system that rests on idea that some people are more worthy or have more worthy claims to movement across borders or to access to safety, economic opportunities, family unity, etc. that borders can, at times, separate. In fact, I think the same infrastructural forces that are usually at play in the oppression of people, whether you're an economic migrant or an asylum seeker, they're the exact same infrastructural forces that are at play. And so, many times, people are both: They're economic migrants, and they're asylum seekers.

HOFF: Sure.

JANEWAY: And so, you can add to this the knowledge that the infrastructural forces that cause migration, which are like the fundamental forces of colonialism, U.S. imperialism, neoliberalism, and the militarization of borders, which are honestly, generally left out of conversations about border health.

HOFF: Right.

JANEWAY: Many times, migrant health is kind of considered in the context of humanitarian crises rather than as a result of these ongoing political economic policies. And you can add to that the fact that borders are not natural divisions. They're these ideological lines that are drawn by and through political power, many of them drawn during colonial eras as part of colonial power plays. And therefore, they have a huge role in producing disease and death. And if you really want to tackle the root cause of what's causing these people to suffer, you really, really need to consider abolishing borders.

And then I added to this as myself, as an individual, my own levels of privilege, whereby I'm allowed to cross a border every day that my patients are waiting in hard conditions to cross for years now, all because of the privilege I was given just by my place of birth. And that privilege comes from some of the worst, most shameful parts of U.S. history. So, I think that knowing all of this and believing fundamentally in equity for all, including health equity for all of my patients, the only permanent solution that I can see is the dissolution of borders that we created to set up these systems of inequality. Most health care providers, I think, who truly believe in the creation of health equity should in fact also be border abolitionists for all those reasons that I mentioned above.

HOFF: Great. Thank you. That phrase of "border abolition" is likely to sound threatening to a lot of people, I think. Can you talk a little bit more about how you came to identify with the term and what you might say to people who are initially put off by it?

JANEWAY: Yeah. So, I give a lecture on activism in medicine. And I think the most important thing I say during the lecture is that if you look at human history and how major changes have occurred in human history, those only happen when people are willing to risk something. Many, I think, of the movements in the past that have created important change have involved people, actually people who usually have literal privilege, sacrificing some of that little privilege that they have to create change. I think as health care professionals, we have privilege in society that goes beyond our own individual privileges as people. I can give myself as an example. I am a white person, and so I have a lot of privilege that just comes from being white. I grew up in a middle-class family, so I have

some economic privilege. And we can all break down our individual levels of privilege. But doctors on top of that kind of have this moral, ethical privilege and privilege that people give us as being sort of leaders in society. And so, I think that as part of creating a better world, we as physicians have to be willing to sacrifice some of our privilege so that it can be spread more equally to others.

I think border abolition, the idea of it sounds scary, but borders cause oppression by upholding systems of inequality just like systems like apartheid or slavery did. And I think at that time, people of privilege and power were also threatened by dissolving them. But it was also absolutely the right thing to do in the context of human evolution. I've been scared too at times even of my own ideas and the idea of border abolition. But I fundamentally know that the ideas that make me the most uncomfortable are the ones that are in challenging my inherent privilege and thus are likely the most worthwhile and the ones that we need to think about at the greatest length. I think all of us need to take time to sit with feelings of discomfort and work through those feelings so that we can be the people and patient advocates and changemakers that we want to be.

I often think of the movement for border abolition in the context of the movement for prison abolition, which can offer, I think, a lot of guidance for border health activists. Borders, like prisons, are just like physical structures of control that are rooted in really oppressive infrastructures that have excluded and traumatized and criminalized and oppressed the most vulnerable populations. Like in prison abolition, the goal is to deconstruct infrastructures that justified the existence of borders. And if you think about prison abolition, for instance, a prison activist might fight for better mental health services for incarceration, and that fight might actually end up just creating larger prison complexes that actually just reinforce the system instead of breaking down the system itself. And I think this is actually what we do at times at the border. I'm definitely guilty of this. Instead of focusing on abolition and the forces that uphold that, we kind of focus in on these mini-issues.

HOFF: Hmm.

JANEWAY: Such as yesterday, like I said, I went and I did medical screenings for people who are under MPP. And those screenings are probably reinforcing the structure of the border and the fact that borders are legitimate and not creating these systems of inequality, which they absolutely are. It doesn't necessarily mean that borders need to come down tomorrow. I don't think that's realistic, but it does mean that I think we have to engage in creating new global economic systems so that someday borders won't be needed. And we need to address the root causes of the forces that cause displacement and not only just address the end effects of displacement itself, which is some of the things that I do in my own work.

So, I try to think of it this way: I think for each activity that I do that reinforces the border, such as what I did yesterday, I need to be doing two or three things that are working to actively taking borders down. As a physician who works at the border, I realize that my work can be problematic in that sense, problematic in the sense that it does sometimes reinforce the borders. But I also believe that the people that I'm serving deserve to have health care and a reduction to their suffering. But at the same time, I also know that that suffering will never end until I do my part in trying to bring down and take down the forces that are creating the systems to begin with.

HOFF: What would be some examples of, let's call it an abolitionist model of care? Are there things that health professionals can do in their capacity as people caring for patients? Or is the project of border abolition something that can only happen at a policy level?

JANEWAY: Yeah. So, I think as health care professionals one of the things we can do is take risk. So, something that I've been doing since the beginning of COVID-19 is I've continued to go down to Tijuana, I've continued to cross that border, and I've continued to bring the highest level of health care that I can to people across the border, no matter what side of the border they're on. Whether they're in Los Angeles or they're in Tijuana, I try to commit myself to breaking down the difference in care that exists across the border. So, that is something that I've done as a risk to myself, because I think a lot of people have been fearful of going anywhere outside of their own bubble because of the risk secondary to COVID-19, because of their, maybe their job has put up some restriction, or because of a host of other factors. And I think our organization has been really intentional about continuing to break down those border inequalities that have been set up, especially during the pandemic.

But I think a lot also of what we need to do is work with local organizations and people who have been really active in the border abolitionist movement. There are a lot of Indigenous groups that are working along the border, especially the southwest border, who have done some really amazing work to try to work towards border abolition. There are people who are doing great works trying, great work trying to recreate economic systems. And I think as physicians, we need to step back, and we sometimes need to engage in things outside of health care in order to, as allies using our privilege, in order to move movements forward in any way that we can.

HOFF: Great. Thank you. Given some of the atrocities that have been reported, for example, deaths, forced sterilizations, the forced administration of psychotropic medications to children, the indefinite separation of infants and children from their parents, the deportation of patients known to be infected with SARS-CoV-2, some might begin to wonder how any clinician who's taken an oath to motivate the best interests of their patients could even consider working for a U.S. agency like Customs and Border Protection or Immigration and Customs Enforcement. The health professionals in these positions seem to run into numerous conflicts between their professional ethical responsibilities and the requirements of their employers, for example, as mandatory reporters of abuse and neglect. When the party committing the abuse and neglect is the federal government, how should conscientious clinicians mandatorily report in the first place? What do you recommend they do in that scenario?

JANEWAY: So, the conditions in CBP and ICE custody are very concerning to me as a physician. I've had countless patients come to visit our clinic and recount to me how they were denied medical care or mistreated inside of detention. And of course, there's the long list of individuals who've lost their lives secondary to not having access to medical care. As a U.S. citizen, I think these stories were heartbreaking, knowing that my tax dollars and my country is doing this to other human beings. And I can imagine a lot of reasons people take positions within an oppressive system. And I wish that all of them were doing it to create change. But unfortunately, I don't think that's the case or we would have seen a movement from health care providers in these settings to create change.

Instead, I think many have taken the stance that has been seen commonly when people justify their neglect by saying that they're just following orders or are cogs in the wheel,

that they can't change anything. And because of that, I mean, I haven't seen, you know, CBP doctors or ICE physicians come out and take a stance against what's happening, which is really sad to me as a physician, knowing that these are my colleagues. I'm currently working on a project that deals with the reporting of law enforcement abuse to third party agencies for the same reasons you outlined above. It doesn't make sense that if you've been abused by a system, in order to report your abuse, you have to go back to your abusers and ask them to investigate it. And I think something similar really needs to be created for ICE and CBP.

When I and members— So, I work with a group that's called Doctors for Camp Closure. They're this amazing advocacy group that has been doing a lot of work trying to close all detention facilities that hold migrants and immigrants in the United States. And last year, we actually held a peaceful protest and a direct action to ask CBP to vaccinate people in their custody against the influenza virus and prevent many preventable deaths. And this was in response, obviously, to children dying in CBP custody from the flu. And at that time, several of us were actually arrested in a peaceful protest, trying to get them to allow us to vaccinate these people. We had brought everything. We had the vaccines. We had the consents. We had people to vaccinate who were licensed in the state of California. And unfortunately, they denied us access to providing this vital health service to migrants.

In response to that, the media coverage and a lot of congressional support for the movement to really hold CBP accountable, we were actually invited to the White House to meet with the head physician for CBP. And we actually demanded of CBP that there be an independent oversight committee to look into health care at their facilities and how to best assure that the health of migrants was protected if they were going to detain people. And I still haven't seen that happen. Other than the court-mandated Flores settlement, I've seen no such independent body looking into these horrific stories that migrants have been telling not just me, but colleagues all across the country who have received patients who have been crossing the border over the last four years in their facilities. And that's really concerning to me, that there's no place for my patients to go to report the abuses and the lack of medical care and attention that they were denied.

HOFF: So, has there been any development in the creation of some kind of third party reporting, or is it just still in limbo since you first approached?

JANEWAY: I mean, we.... No, I mean, so basically, this was right before COVID-19 began that we met with him. I think it was in February of 2020, February 2020. And that is what we asked. We asked for there to be an independent oversight committee that would be looking into health and health care in these facilities. And I have not been informed, at least personally or through my advocacy efforts, that any such committee has been created or is slated to be created. But I haven't seen any plans also coming out of the Biden administration yet. I know that there was some plans promised in the first 100 days, and I hope that that is something that we can count on and see. Because really, health care should be left to health professionals, and those health professionals should be independent monitors of health and wellness in those facilities.

And right now, the way that it works in many ports of entry and in many Border Patrol stations is that there's no health care provider, and the health of migrants is left in the hands of untrained officers who often miss critical signs of illness in people and deny requests for medical care to migrants who are asking for them. So, in other words, I haven't heard that, you know, that was our request. That was our principal request of them when we met with them. And that was the principal requests that we communicated as

well to members of Congress that were in support of these efforts. And as far as I know, there has not been, other than what was mandated by this for the Flores settlement, there has been no such oversight committee that has been created, especially to look into health provision in the state of California.

HOFF: Sure. Well, I hope that this year brings some movement on that project. It sounds like a very worthwhile endeavor. And hopefully we can have you on again soon to talk about some positive advancements on that front. In the meantime, thank you very much for joining us today and for sharing your expertise on these important issues. [theme music returns]

JANEWAY: Absolutely. It would be my pleasure.

HOFF: That's our episode. Thanks to Dr Hannah Janeway for joining us. Music was by the Blue Dot Sessions. For more from the *AMA Journal of Ethics*, please visit our site, JournalOfEthics.org. Follow us on [Twitter](#) and [Facebook](#) @JournalOfEthics. And we'll be back next time with an episode on compassionate uses of force in health care. Talk to you then.