The NEW ENGLAND JOURNAL of MEDICINE

Perspective

JULY 23, 2020

Border Babies — Medical Ethics and Human Rights in Immigrant Detention Centers

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Providing decent medical care for families in U.S. detention centers near the Mexican border has become exceedingly difficult over the past 2 years. Trauma was inflicted on migrants to deter others from attempting to enter the United States. A cornerstone of deterrence was the "zero tolerance" policy that forcibly separated children from their parents at the border. Photographs of children confined in cages horrified Americans, who demanded that the policy be rescinded. It was, but family separations continue and have been made even worse by the Migrant Protection Protocol (MPP) — which the U.S. Supreme Court will most likely review later this year — under which asylum seekers and their children are returned to Mexico to wait in makeshift camps for their applications to be reviewed. This practice has created yet another humanitarian crisis.[1]

How can physicians working in detention centers safeguard children's health? Unable to identify any public statements by physicians employed by the Department of Homeland Security (DHS), we interviewed physicians caring for the children and their parents to learn what ethical dilemmas they had confronted. Using key informants and the media, we identified physicians and psychologists who have cared for migrants at the border, either in detention, postdetention, or at local hospitals. We invited 36 to participate and had 15 positive responses. One of us (S.S.C.) conducted 13 audiotaped interviews by telephone and 2 in person. Although it wasn't our intended goal, we also interviewed lawyers representing detained migrants, as well as nurses and social workers who worked for local nongovernmental organizations (NGOs) and examined court records that included health care notes.

A primary finding was that since they were not present when families were separated or when children were placed in cages, physicians could not prevent those abuses. But other ethical challenges are common. Physicians working in private medical institutions where migrants are brought from detention centers for care feel conflicted when their medical judgment is challenged or superseded by detention authorities, and they don't always feel supported by their institutions. For example, doctors in local private hospitals caring for sick or pregnant migrants reported feeling coerced into writing "clearance" letters for migrants to be returned to detention or encampments in Mexico. Some respondents acknowledge the trauma caused by family separation and indefinite detention but feel helpless to reunite families. One contract cli-

nician who worked in a detention center from 2013 to 2015 said he resigned because he was not permitted to provide medically necessary treatment to detainees and "could not take it anymore."

Nonetheless, many individual physicians and groups, in both the United States and Mexico, are providing services. Volunteer physician groups provide care, in shelters and improvised clinics, primarily through NGOs. Interviewees consistently reported that migrants' medications were confiscated when they arrived in Customs and Border Patrol (CBP) detention — including medications for asthma, diabetes, and hypertension. No medical records are given to migrants upon release, which obstructs postrelease care. Multiple incidents of substandard care in detention centers were described, and deficiencies have been documented by the DHS Office of the Inspector General.[2,3] A lawyer described how her ill client was "cleared by an ICE doctor" for deportation. One volunteer doctor, describing care for people in CBP custody, remarked, "[CBP officials] don't see them as human beings."

Clinicians felt isolated and unsupported. One thought medical organizations should be saying, "This is absolutely unacceptable and we will not stand for it." Another described facing an ethical challenge when caring for migrants with chronic medical conditions or pregnancy after their release from detention. The physician believed that putting these migrants on a bus and offering no mechanism for continuity of care was simply bad medical practice. Another said, "This crisis is so massive and so badly organized . . . if this were happening in Somalia or Bangladesh, the UN would step in and coordinate, but because it's in the U.S. there is no coordinating body, so it's the Wild West of humanitarian responses, it's pure chaos."

Two physicians who work as contract inspectors for DHS filed a whistleblower report with the U.S. Senate, and 14 medical organizations wrote the Senate a letter saying the report showed "possible medical neglect and child endangerment and merit[ed] congressional inquiry and oversight." In 10 investigations of family detention centers the inspectors conducted over 4 years, they identified a "high risk of harm" to migrant children housed at such facilities. They concluded, "In our professional opinion, [forcible family separation] was an act of state sponsored child abuse whose specific consequences will significantly threaten the children's health and safety. . . . Detention of innocent children should never occur in a civilized society" (www.whistleblower.org/wp-content/uploads/2019/01/Original-Docs-Letter.pdf).

In the past, such "naming and shaming," shining a light on human rights violations, has often motivated change. Reactions to the whistleblower complaint suggest that such revelations no longer have that effect. The Trump administration is not ashamed of its child-separation policy and has arguably made life even worse for children with the MPP policy. When the Covid-19 pandemic began, the administration ordered all undocumented persons arriving at the Mexican and Canadian borders, including asylum seekers and unaccompanied minors, to be summarily excluded from the country. No medical screening takes place.

How should the profession respond when government policy conflicts with medical ethics and human rights? We agree with many of our interviewees that the medical profession should do more to support and protect physicians who are pressured to compromise patients' health. One interviewee persuasively suggested that physicians need formal "Know your rights" training and an ethics hotline where senior clinicians can provide guidance on specific cases. It seems reasonable to suggest that the Association of American Medical Colleges require medical schools to provide human rights education so that government-employed physicians in potentially compromised positions can effectively advocate for patients (see box). Volunteer physicians have responded heroically to this crisis, but they need more support from both the profession and their institutions. Instead, some hospitals actively discourage volunteer work at the border and warn physicians not to

Major Human Rights and Medical Ethics Principles.

World Medical Association's Declaration of Geneva
"I will not use my medical knowledge to violate human rights and civil liberties, even under threat."

The Convention on the Rights of the Child
Article 9, "States Parties shall ensure that a child shall not be separated from his or her parents against their will."

The International Covenant on Civil and Political Rights
Article 7, "No one shall be subjected to...cruel, inhuman or degrading treatment."

The International Covenant on Economic, Social, and Cultural Rights
Article 12, "[We] recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."

use their employer's name when identifying themselves.

Professional organizations are beginning to take medical ethics and human rights more seriously, and we believe that they should support health care workers who face ethics challenges in their work. The American Academy of Pediatrics was the most vocal medical professional organization calling for ending family separations and child detention, and it should be commended for its advocacy. In November 2019, American Medical Association President Patrice Harris released a statement declaring that "delivering substandard healthcare to detained immigrants along the U.S.-Mexico border — or providing no care whatsoever — is a fundamental violation of human rights" (www.healthline.com/health/opinion-on-human-suffering-at-the-southern-border#1).

Nevertheless, many interviewees thought that more needed to be done to promote transparency and accountability in detention and medical care and that professional organizations should be leaders in halting unethical medical practices that harm detainees. Providing influenza vaccination is too little too late and takes the focus off the holistic care required.[4] CBP agents and immigration judges have spoken out after quitting their jobs; no physician working in detention centers has gone public, even after resigning or retiring. We believe that physicians need to speak out to protect patients, and that medical licensing boards should support these physicians if they must break nondisclosure agreements (NDAs) to do so. It is unethical for physicians to sign an NDA that restricts their ability to discuss the quality of care available to their patients.

Perhaps the most difficult ethical question clinicians face in detention centers is when, if ever, they should simply refuse to provide medical services in an inherently cruel setting.[5] We believe that refusal should be based on recognition that one would be complicit in cruelty if one did not object to cruel practices, such as family separations, both internally and publicly. Clinicians should quit this work when a reasonable medical observer would conclude that by their presence they are doing more to enable human rights abuses than to prevent them.

Providing decent medical care at the border is not a partisan issue; it is a straightforward matter of ethics and human rights that the medical profession should insist on. To help protect patients, physicians should learn universal human rights principles and professional associations should support them in upholding these rights. When physicians who work in detention centers feel isolated and unprotected by their profession, their patients' health and lives are at risk.

Disclosure forms provided by the authors are available at NEJM.org.

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DOI: 10.1056/NEJMp2003050

Failing the Test — The Tragic Data Gap Undermining the U.S. Pandemic Response

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As the United States navigates one of the most serious pandemics in history, much of the country has been shut down to prevent devastating local outbreaks that threaten lives and can overwhelm hospitals. A breakdown in the federal disaster response delayed state and local responses, allowing SARS-CoV-2 to spread rapidly in New York, New Jersey, Michigan, Louisiana, and other states. Only astute early interventions in Seattle and the San Francisco Bay Area seem to have stemmed a potential tide of cases and deaths. Covid-19 has taken more American lives in 1 month