

**A Defense of physician advocacy: Advocating for the health of undocumented
immigrants in the United States and Colombia**

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Undocumented immigrants face different difficulties and barriers in order to access the health care system. Even when they get to access medical care, they face situations of xenophobia, discrimination and the fear towards their legal status can affect their experience and can have an impact in the continuity and success of their treatments. In a context of migration emergencies in both the United States and Colombia, immigration measures and policies have directly impacted the health outcomes of undocumented immigrants, creating a situation of a structural health injustice. This thesis argues that advocacy is a way in which physicians can successfully contribute to document, address and tackle this injustice and improve the lives and health of undocumented immigrants. This thesis defends physician advocacy by arguing that: i) Advocacy actions are connected and grounded in the legitimate goals of medicine and their contemporary reinterpretation. In this line, advocacy can be an effective way to promote health justice and contribute to restore the trust that undocumented immigrants have lost in doctors; ii) advocacy actions are an effective way in which physicians can take advantage of their unique position based on their historical social privilege and the access they have to undocumented immigrants' health. Furthermore, to show how physicians can advocate for the health of undocumented immigrants, using their knowledge and expertise, this work analyses the case of: i) Sanctuary Doctoring, ii) Physicians for Human Rights and iii) Profamilia-Colombia.

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Preface

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1.0 Introduction

Migration, as a population phenomenon, affects different aspects of immigrants and the lives of people in recipient countries and can transform communities' dynamics. Immigration commonly has been framed as a threat to recipient societies and governments, and communities have constructed problematic stereotypes around immigrants. An example of this can be traced back to the history of eugenics when different nations constructed the concept of *social degeneration* in the beginning of the twentieth century as a response to increasing rates of immigration during the interwar period, changes in the social dynamics, economic depression, increasing urbanization and new demands from society, among others.¹ Thus, eugenic measures in North America and Europe frequently framed immigrants as feeble-minded and portrayed the increasing immigration phenomenon as a "racial suicide".² Contrary to this, in the context of Latin America, during the eugenic period governments considered "white immigration" as a solution for the "racial problem" which consisted in the presence of African descendants and indigenous populations.³ Therefore, throughout history, whether immigration is discouraged or encouraged has depended on society's view of immigrants' socio-economic, ethnic, etc. characteristics. An important factor has been negative attitudes towards immigrants, especially the ones that come from racial minorities and speak different languages. This includes generalized attitudes of

¹ Nancy Ley Stepan, *The Hour of Eugenics. Race, gender and nation in Latin America* (New York: Cornell University Press, 1991), 24.

² Ibid.

³ Carlos Ernesto Noguera, *Medicina y Política. Discurso médico y prácticas higiénicas durante la primera mitad del siglo XX en Colombia* (Medellin: Fondo Editorial Universidad EAFIT, 2003)

mistrust from citizens and authorities as they fear immigrants might take jobs from national citizens and bring diseases and insecurity.⁴

Even though immigration has been a constant phenomenon in history, over the last two decades social, political and economic crises, wars and natural disasters have substantially increased migration in different parts of the world. Recent conflicts and disasters have forced thousands of people to leave their countries, looking for better opportunities, running from threats and violence and seeking humanitarian assistance.⁵ An example of this are the immigrants displaced by the complex crises and wars in Libya, Syria, Sudan and Venezuela, the increased numbers of immigrants crossing the Mediterranean Sea and the US southern frontier and immigrants looking for shelter after natural disasters in Haiti and Thailand.⁶ Also, recent politics surrounding immigration have exacerbated negative social attitudes, discriminatory treatment, xenophobia, detention, lack of social protection and abuse from authorities.⁷

Immigration can be defined as the act of moving from one country to another in order to adopt a new residence.⁸ This process can involve regular and irregular ways. For the purposes of

⁴ Maegan Hendow, “When Disaster Strikes: Responding to Migrants Caught in Crises”, *Migration Policy Institute*, (September 2018).

⁵ Vicki Squir, Angeliki Dimitriadi, et al “Crossing the Mediterranean Sea by Boat: Mapping and documenting migratory journeys and experiences”, University of Warwick, Hellenic Foundation for European & Foreign Policy (ELIAMEP), (February 2019).

⁶ Maegan Hendow, “When Disaster Strikes: Responding to Migrants Caught in Crises”, *Migration Policy Institute*, (September 2018).

⁷ Ibid, 3.

⁸“Key migration terms”, International Organization for Migration (IOM), accessed May 1, 2020, <https://www.iom.int/key-migration-terms>

this thesis, I will focus on irregular migration, which the International Organization for Migration (IOM) defines as a “movement of persons that takes place outside the laws, regulations, or international agreements governing the entry into or exit from the State of origin, transit or destination”⁹. In the context of irregular immigration, the United Nations has rejected the term *illegal immigrants* and instead recommends using terms such as *undocumented immigrants* or *irregular immigrants*.¹⁰ Therefore, in order to promote a respectful, humanizing and dignified characterization of immigrants, I will use the term *undocumented immigrants* to describe immigrants that have used non- regular ways to enter their destination country.¹¹ When referring to undocumented immigrants I understand that even if their legal status is “undocumented” in the country they migrated to, this does not mean that they do not have documents, an identity and a history in their home countries. Also, I understand this status can be transitory and can vary according to the different international legal dispositions about asylum and refugee.

More precisely, I focus on the context of immigration in the United States and Colombia. Both countries have received an unprecedented flow of irregular migration over the last two decades from Latin America, which is experiencing the “largest migration crisis in its modern history”¹². Migration from Central America is related to the ongoing political and social crisis in the *Northern Triangle countries* that involves gang violence, drug cartels, corruption, social crisis and various

⁹ Ibid.

¹⁰United Nations, “Why “Undocumented” or “irregular”?”, accessed May 6, 2020, https://www.unhcr.org/cy/wp-content/uploads/sites/41/2018/09/TerminologyLeaflet_EN_PICUM.pdf

¹¹ Ibid.

¹² World Politics Review, “Corruption and violence not failed ideologies are driving Central American exodus”, accessed August 1, 2019, <https://www.worldpoliticsreview.com/articles/28086/corruption-and-violence-not-failed-ideologies-are-driving-central-america-s-exodus>

human rights violations.¹³ In the context of Colombia, the shared frontier with Venezuela has created a humanitarian migration crisis. The ongoing Venezuelan political and social crisis has exponentially increased immigration rates during the last 5 years.¹⁴ Considering this migration phenomenon, it is important to think about the undocumented immigrants and their health situation.

Undocumented immigrants that are arriving to the United States and Colombia face profound difficulties to access health care. In particular, undocumented immigrants face obstacles to access health insurance and many of them have to rely on emergency services to get basic health care.¹⁵ Moreover, undocumented immigrants tend to face many barriers when they are navigating the health services. These barriers include stigma, discrimination and fear of sharing their information and revealing their immigration status.¹⁶ Many, avoid going to hospitals or clinics and feel they cannot trust their physicians.¹⁷ This situation has a clear impact on the health situation of undocumented immigrants in both countries, who tend to face higher rates of preventable diseases

¹³ Ibid.

¹⁴ Mercy Corps, “Quick facts: Venezuela’s humanitarian crisis”, accessed August 13, 2019, <https://www.mercycorps.org/articles/venezuela-crisis-quick-facts>

¹⁵ Mark Kuczewski, “Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients”, *The American Journal of Bioethics*, 19 no 4 (2019): 51-57.

¹⁶ Shamsheer Samra, Breena R. Taira and Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine*, 20, no. 5 (Sep, 2019).

¹⁷ Mark Kuczewski, “Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients”, *The American Journal of Bioethics*, 19 no 4 (2019): 51-57. Also see: Mark G. Kuczewski, Johana Mejias-Beck, and Amy Blair, MD, “Good Sanctuary Doctoring for Undocumented Patients”, *AMA Journal of Ethics*, 21, no 1 (Jan, 2019): 78-85.

and other health conditions. Also, undocumented immigrants tend to have no access to (quality) health care in their home countries, which complicates their health situation upon arrival.¹⁸ Moreover, recent immigration policies and regulations have targeted and stigmatized undocumented immigrants in both countries. Specifically, the United States has promoted measures such as family separation and detention, which have affected the physical and mental health of immigrants and increased the fear among this community.¹⁹

1.1 The role of doctors in addressing health disparities

Advocacy is not new for physicians. For Mark Earnest, medical society affiliation, coalition building, the provision of advice for policy makers and the contribution to media and health reporters are ways in which physicians can advocate for health care.²⁰ For Earnest, advocacy doesn't require physicians to become experts in other fields of knowledge such as public policy or law. Instead, advocacy is grounded in "their professional experience and work life"²¹. Tracing back the history of social medicine in different parts of the world and its long-standing tradition in

¹⁸ Profamilia and the Office of the United States for Disaster Assistance Abroad (OFDA-USAID), *Health inequalities of the migrant population and a Venezuelan refugee in Colombia. How to improve local response within the humanitarian emergency?* (Bogota: Profamilia, 2020).

¹⁹ Physicians for Human Rights, "The Impact of Immigration Detention on Migrant Mental Health", *PHR Issue Brief*, (Oct, 2018).

²⁰ Mark A. Earnest, Shale L. Wong and Steven G. Federico, "Perspective: Physician advocacy: what is it and how do we do it? *Acad Med*, 85 no 1 (Jan 2010): 63-67.

²¹ Ibid, 63.

Latin America, it is possible to see that physicians historically have been involved with the structural, economic and social causes of illness and have promoted transformational reforms.²² In this way, social medicine exponents have shown how medicine can be involved in advocacy with research, education and political practice.²³

Currently in the U.S. there are several examples of physicians' advocacy, including their increasing participation in gun control reform²⁴, their efforts against water poisoning in Michigan²⁵, their growing interest in advocating for and learning about climate change²⁶, and their participation in public health policies related to smoking and obesity control.²⁷ However, the scope of my thesis is limited to the health of undocumented immigrants, considering the current political climate and the number of barriers this population is currently facing.

²² Howard Waitzki, "Social Medicine Then and Now: Lessons From Latin America", *American Journal of Public Health* 91 no 10 (Oct 2001): 1592-1601.

²³ Ibid, 1600.

²⁴ Mathew Stanbrook, "Gun control: a health issue for which physicians rightfully advocate", *Canadian Medical Association. Journal*, 191 no 16 (2019).

²⁵ American Medical Association, "When water is unsafe, physicians must take up public health roles", Public Health, October 17, 2017, <https://www.ama-assn.org/delivering-care/public-health/when-water-unsafe-physicians-must-take-public-health-roles>

²⁶ Brianna Abbot, "Medical Schools Are Pushed to Train Doctors for Climate Change", *The Wall Street Journal*, August 7, 2017, https://www.wsj.com/articles/medical-schools-are-pushed-to-train-doctors-for-climate-change-11565170205?mod=article_inline

²⁷ Erik Topol, "Why Doctors Should Organize", *The New Yorker*, August 5, 2019, https://www.newyorker.com/culture/annals-of-inquiry/why-doctors-should-organize?utm_source=on-site-share&utm_medium=email&utm_campaign=on-site-share&utm_brand=the-new-yorker

In this thesis I provide arguments in defense of physician advocacy for the health of undocumented immigrants in the context of the immigration emergencies in the United States and Colombia. In order to do this, I provide a definition of physicians' advocacy for undocumented immigrants and I explore a set of ethical arguments to defend physicians' participation in advocacy actions for this population.

1.2 Methodological considerations

In this thesis I use a multidisciplinary perspective. First, I use resources from ethical, philosophical and bioethical perspectives in order to construct the arguments around physicians' ethical duties and the overall goals of medicine and the changes they have undergone through time. Also, when I explain the arguments of justice I rely on philosophical conceptions of justice, considering the egalitarian perspective, the concepts of health justice, structural injustice and restorative justice. Second, I rely on historical works and perspectives in order to reconstruct the role of physicians and how their privileged status has been shaped throughout history. Moreover, I explore the role of medicine in the history of immigration in the United States, in order to understand better the relationship between medical arguments and the exclusion and stigmatization of immigrants. Third, I use legal sources in the case of Colombia, in order to understand the constitutional provisions that have protected the right to health of undocumented immigrants and to explore the most common barriers this population faces. Through the analysis of individual constitutional cases, I was able to explore the reasons why many undocumented immigrants were asking judges to protect their lives and health. Finally, I use studies and research available in

medical journals in order to explore how physicians have understood the health context of undocumented immigrants.

I also use a comparative analysis, in order to show the situation of immigrants in the United States and Colombia and to explore advocacy initiatives in both countries. The selection of the United States and Colombia is motivated by the existence of a massive migration phenomenon from Latin American countries to both of these countries. Also, I selected these countries considering the accessibility of sources and personal interest. The selection of Colombia as a focus of study responds to personal academic interests and to the desire to include the Latin American perspective on the subject. Also, I was inspired by physicians' advocacy initiatives in the United States and I want to use this experience to encourage and motivate physicians to be more actively involved in advocacy in Colombia.

Finally, I explore and analyze literature about immigration and physicians' advocacy in general. The literature that has explored the connection between immigration, advocacy and the role of medical professionals is very recent and new.²⁸ It is mostly in the field of bioethics. I also make use of literature on immigration as a social determinant of health, the social transformation of the medical profession, the internal morality of medicine, and the principles of bioethics.

My thesis includes an introduction, 3 thematic sections and a conclusion. The first section, "Defining physicians' advocacy for undocumented immigrants in the United States and Colombia" provides a definition of physicians' advocacy and examples of the ways in which physicians can act as advocates. This part focuses on explaining the scope of physicians' advocacy I will be

²⁸ It is important to highlight the work of Mark Kuczewski, Nancy Berlinger and Rachel Fabi, as authors in the field of bioethics that have specifically studied the connection between physicians' advocacy and the health of undocumented immigrants in the United States.

covering. Specifically, I answer three questions: i) advocacy for whom?; ii) advocacy for what?; and iii) advocacy by means of what actions/measures?. With this, I explain who are the undocumented immigrants, what barriers they face to access and get proper health care and what are the policies affecting their health. Also, I provide examples of the type of actions and measures that can be considered as part of physicians' advocacy.

The next section, "A defense of physician advocacy" provides three reasons to support physicians' participation in advocacy for the health of undocumented immigrants. These reasons include the analysis of how the role of advocacy is connected with the traditional goals of medicine in the light of the current context of society and pressing circumstances. In this line, I examine how professional organizations and current interpretation of medicine's goals include justice as a legitimate goal and I show how advocacy can be a way in which physicians contribute to addressing and overcoming situations of structural health injustice. Similarly, I explain why advocacy can be a way of recognizing the role that physicians played in past injustices against immigrants and help restore their trust. Moreover, I analyze the roots of the historical privileged social status of physicians and explain why their prestige, technical expertise and the unique access they have to witness people's health support advocating for the health of undocumented immigrants. Also, in this section I consider and rebut arguments used to go against physician advocacy.

Following, the section "Case studies of physicians who advocate for immigrants' health in the United States and Colombia" explores three case studies as examples of the different ways in which physicians are currently involved in advocacy for the health of undocumented immigrants in the United States and Colombia. I analyze the sanctuary doctoring model, the work of Physicians for Human Rights and of Profamilia-Colombia as ways of showing how physicians and medical

institutions can speak out against health injustices, do research to make visible the effects of certain policies on immigrants' health and promote change through their own expertise and experience. At the end, I provide a set of conclusions that ratify the reasons to defend physician advocacy for the health of undocumented immigrants.

2.0 Defining physicians' advocacy for undocumented immigrants in the United States and Colombia

In this section I explain the understanding of advocacy that I will use for the purposes of this thesis. To this end, I will consider three questions: 1) advocacy for whom? 2) advocacy for what? and 3) advocacy by means of what actions/measures?

2.1 Advocacy for whom?

As stated before, in this thesis I will focus on advocacy for undocumented immigrants. In order to understand this population better, it is important to contextualize the population of undocumented immigrants in the United States and Colombia, highlighting their health conditions.

2.1.1 Who are the undocumented immigrants?

Undocumented immigrants usually use unauthorized ways to enter the recipient country. However, immigrants who entered a country legally can become undocumented.²⁹ For example, immigrants can enter a country on a tourist visa and stay after the visa expires. Moreover, undocumented immigrants can be classified as either voluntary or involuntary. According to Messina and Lahav, voluntary immigrants are those who migrate for economic or family

²⁹“Key migration terms”, International Organization for Migration (IOM), accessed May 1, 2020, <https://www.iom.int/key-migration-terms>

reunification reasons.³⁰ Involuntary immigrants are those who are usually “(...) forced to flee their home country to escape violence or persecution; these include refugees and asylees, who migrate for similar reasons but through different avenues.”³¹ This category usually includes asylum seekers who eventually can become refugees who are looking for international protection.³² It is important to recognize that the demographic and political circumstances have changed over time, which has affected the meanings and the scope of who is considered a refugee.³³ These changes are related to “new drivers” that push people to cross borders in difficult situations, such as “environmental change, natural disaster, food insecurity, famine and drought and state fragility.”³⁴ Moreover, these new drivers for migration have pushed authors such as Alexander Betts to be critical about the clear limit between categories of voluntary and involuntary migration. Betts and other authors have argued that many people can “fall between the gaps of the dichotomy between refugee and voluntary economic migrant”.³⁵ Thus, they have used categories such as “external displaced people”, “vulnerable irregular immigrants”, “forced immigrants” and “survival immigrants”.³⁶ Betts defines “survival immigrants” as “persons who are outside their country of origin because of

³⁰ Anthony M. Messina and Gallya Lahav (editors), *The Migration Reader: Exploring Politics and Policies* (Boulder: Lynne Rienner, 2006).

³¹ Ibid.

³² United Nations, Convention relating to the Status of Refugees, adopted on 28 July, 1951, Art. 1A (2).

³³ Alexander Betts. *Survival Migration: Failed Governance and the Crisis of Displacement* (Ithaca: Cornell University Press: 2013), 13

³⁴ Ibid.

³⁵ Ibid.

³⁶ Andrew Selee Jessica Bolter, “An Uneven Welcome. Latin American and Caribbean Responses to Venezuelan and Nicaraguan Migration”, *Migration Policy Institute*, February 2020, 22.

an existential threat for which they have no access to a domestic remedy or resolution.”³⁷ This concept is useful to understand and address the situation of immigrants whose lives are at a clear risk in their home countries but are “at the margins of the refugee regime, falling outside the dominant interpretation of a refugee under the international framework created after the Second World War.”³⁸

The concept of survival migration is very relevant for the dynamics of Latin American immigration to the United States and Colombia, which will be described in this section. Even if many of these immigrants have crossed the borders in a context of survival and desperation, their cases tend not to be considered for asylum and they are usually not considered refugees under the legal definition adopted in both recipient countries. However, they should not be considered voluntary immigrants, as their home countries face complex political, economic and social conflicts, which is reflected in very high rates of violence, food insecurity, sexual violence, lack of health care services, generalized political prosecution, among others.³⁹

2.1.2 Undocumented immigrants in the United States

The United States has received an unprecedented flow of irregular migration over the last two decades from Latin America, which is experiencing the “largest migration crisis in its modern

³⁷ Alexander Betts. *Survival Migration: Failed Governance and the Crisis of Displacement* (Ithaca: Cornell University Press: 2013), 23.

³⁸ Ibid, 188.

³⁹ Ibid.

history”⁴⁰. Migration from Central America is related to the ongoing political and social crisis in the *Northern Triangle countries* that involves gang violence, drug cartels, corruption, social crisis and various human rights violations.⁴¹ Currently, there are an estimated 11.3 million undocumented immigrants in the United States.⁴² From this population, 47 percent are women and approximately 9% are minors.⁴³ Moreover, Médecins Sans Frontiers argues that “(...) over half of migrants reported violence as the primary driver of emigration while 68.3% endorsed being victims of violence en route”⁴⁴. According to the Migration Policy Institute, 53 percent of undocumented immigrants in the United States are from Mexico. The rest come most commonly

⁴⁰ World Politics Review, “Corruption and violence not failed ideologies are driving Central American exodus”, August 1, 2019, <https://www.worldpoliticsreview.com/articles/28086/corruption-and-violence-not-failed-ideologies-are-driving-central-america-s-exodus>

⁴¹ Ibid.

⁴² Julia Gelatt and Jie Zong, “Settling In: A Profile of the Unauthorized Immigrant Population in the United States”. Migration Policy Institute, November, 2018, <https://www.migrationpolicy.org/research/profile-unauthorized-immigrant-population-united-states>

⁴³ Shamsher Samra, Breana R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798, 791.

⁴⁴ David P Eisenman, Lillian Gelberg, Honghu Liu and Martin F Shapiro, “Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence”, *JAMA* 290 no 5 (Aug 2003): 627-34 cited in Shamsher Samra, Breana R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798, 794.

from El Salvador, Guatemala, Honduras, China and India.⁴⁵ In most states, immigrants are from the Northern Triangle of Central American, which includes El Salvador, Guatemala, or Honduras.⁴⁶ Thus, 90 per cent of all undocumented immigrants in the United States are from Central America and considered from a Latinx origin.⁴⁷ Sixty two per cent of undocumented immigrants have been living in the United States for at least 10 years and 21 per cent for 20 years or more.⁴⁸ This information is important to understand the ties and settlement process of undocumented immigrants in the United States.

Undocumented immigrants in the United States have also been recently impacted by the different immigration measures taken by the Trump administration since the 2016 election. Undocumented immigration to the United States has been frequent through the Mexican border, but the Trump administration had taken measures to reduce the numbers of undocumented immigrants entering the country, push the ones living in the country to return and disincentivize the ones wanting to migrate to the United States.⁴⁹ Some of these policies include: i) regulations that restrict asylum seeking criteria and agreements with Central American countries to send

⁴⁵Julia Gelatt and Jie Zong, Migration Policy Institute, “Profile of the Unauthorized Immigrant Population in the United States”, November, 2018, <https://www.migrationpolicy.org/research/profile-unauthorized-immigrant-population-united-states>

⁴⁶ Ibid.

⁴⁷ Ibid.

⁴⁸ Mark Kuczewski, “Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients”, *The American Journal of Bioethics* 19 no 4 (2019): 51-57, 51.

⁴⁹ Sarah Pierce and Jessica Bolter, “Dismantling and Reconstructing the U.S. Immigration System. A Catalog of Changes under the Trump Presidency”, *Migration Policy Institute*, July 2020, 2.

asylum seekers abroad and to make them wait in Mexico and their own countries⁵⁰; ii) an executive order from January of 2017 that made undocumented immigrants “a priority for arrest ” and doubled the number of arrests of non-criminal immigrants by the U.S. Immigration and Customs Enforcement (ICE)⁵¹; iii) the attempt to end the Deferred Action for Childhood Arrivals (DACA), for children being brought to the United States by their parents at a young age. Although the U. S. Supreme Court overruled this attempt in 2020, the program was significantly limited⁵²; iv) separation of undocumented families⁵³; and v) the 2017 travel ban against certain African and Middle East countries⁵⁴. These measures had an impact on immigration flows and the denial of refugee admissions. By 2020, applications for green cards decreased by 17 percent and deportations increased by 49 percent. Furthermore, refugee admissions went from 84.994 in 2016 to 22.491 in 2018, and by 2020, refugee admissions were at the “lowest level since the modern U.S. refugee resettlement program began in 1980”⁵⁵.

In terms of the undocumented immigrants’ social situation, by 2018, 47 per cent “had less than a high school diploma, 15 percent had a bachelor’s or higher degree.”⁵⁶ Moreover, 36 per cent of undocumented immigrants speak English. For most of them Spanish is their first language and

⁵⁰ Ibid.

⁵¹ Ibid.

⁵² Ibid.

⁵³ Ibid.

⁵⁴ Ibid.

⁵⁵ Ibid, 3.

⁵⁶ Julia Gelatt and Jie Zong, “Profile of the Unauthorized Immigrant Population in the United States”, *Migration Policy Institute*, November, 2018, <https://www.migrationpolicy.org/research/profile-unauthorized-immigrant-population-united-states>, 5.

some of them speak indigenous languages.⁵⁷ They are often employed in low-wage jobs and occupy high-risk occupations.⁵⁸ Sixty seven per cent of the undocumented population were employed at the end of 2018 and their most common jobs included construction, service industries, food services, waste management service and manufacturing.⁵⁹ Their employment situation has significantly impacted their financial situation as by 2018, 40 per cent “had household incomes of at least twice the poverty level.”⁶⁰ The annual report *Income and Poverty in the United States* of 2017 established that Latinx had declined in poverty rates, “dropping down 1.1 percentage points to 18.3 percent from 2016 to 2017”⁶¹. This recently gained economic stability has allowed 34 per cent of undocumented immigrants to own their homes in the United States.⁶² However, the 2020 COVID-19 pandemic drastically impacted the social and economic situation of undocumented immigrants in the United States. According to the Migration Policy Institute before the pandemic unemployment “(...) was lower among immigrants than natives in every major racial/ethnic group.

⁵⁷ Ibid, 6.

⁵⁸ Ashley Edwards, “Hispanic poverty rate hit in all time low in 2017”, *United States Census Bureau*, February 27, 2019, <https://www.census.gov/library/stories/2019/02/hispanic-poverty-rate-hit-an-all-time-low-in-2017.html>

⁵⁹ Julia Gelatt and Jie Zong, “Profile of the Unauthorized Immigrant Population in the United States”, *Migration Policy Institute*, November, 2018, <https://www.migrationpolicy.org/research/profile-unauthorized-immigrant-population-united-states>, 7.

⁶⁰ Ibid, 8.

⁶¹ Ashley Edwards, “Hispanic poverty rate hit in all time low in 2017”, *United States Census Bureau*, February 27, 2019, <https://www.census.gov/library/stories/2019/02/hispanic-poverty-rate-hit-an-all-time-low-in-2017.html>

⁶² Julia Gelatt and Jie Zong, “Profile of the Unauthorized Immigrant Population in the United States”, *Migration Policy Institute*, November, 2018, <https://www.migrationpolicy.org/research/profile-unauthorized-immigrant-population-united-states>, 7.

But since the pandemic took hold, unemployment has risen faster for immigrants than U.S.-born workers.”⁶³ Furthermore, it is important to mention that among Latinx immigrants, by June of 2020 women had the highest jobless rate with 22 per cent.⁶⁴ Even if all low paid workers living in the United States have faced a massive job loss, Latinx immigrants have been specially affected as they tend to be younger, have a low level of education and work in the businesses that were hit the hardest.⁶⁵

Even if the situation of undocumented Venezuelans in Colombia might be different than the situation of Latinx immigrants in the United States, considering the particular circumstances in both recipient countries, undocumented immigrants share certain experiences and characteristics transnationally.

2.1.3 Undocumented Venezuelan immigrants in Colombia

Due to the ongoing armed conflict that started on the 1960’s and difficult economic circumstances, Colombia has usually been understood as a country where people migrated from.⁶⁶ However, as of 2015, Colombia has become an immigration recipient country, as it has received a large number of immigrants from Venezuela. The ongoing political, economic and social crisis in Venezuela that worsened on 2013, has exponentially increased immigration rates, and by 2020 has

⁶³ Randy Capps, Jeanne Batalova and Julia Gelatt, “COVID-19 and Unemployment: Assessing the Early Fallout for Immigrants and Other U.S. Workers”, *Migration Policy Institute*, June, 2020, 4.

⁶⁴ Ibid.

⁶⁵ Ibid, 12.

⁶⁶ Foreign Ministry of Colombia, “Historical background and causes of migration”, accessed 20 April, 2021, <https://www.cancilleria.gov.co/colombia/migracion/historia>

pushed nearly 90% of the country's population below the poverty line.⁶⁷ According to Foreign Affairs, "between 2013 and 2019, the Venezuelan economy shrank by more than half."⁶⁸

Furthermore, since 2014 the health care system has progressively collapsed, pushing almost 13,000 doctors to leave Venezuela and millions of patients to look for medicines and treatments in different countries.⁶⁹ By 2017, there was an estimated shortage of around 85 percent of the required medicines in the country.⁷⁰ Venezuelans also suffer from malnutrition and this particularly affects pregnant women and children.⁷¹ By 2021, the main causes of immigration from Venezuela are food and basic goods scarcity, lack of health and job opportunities, violence and insecurity, the collapse of basic services, the deterioration of education, political persecution against government opponents and journalists, and lack of prenatal and postnatal care.⁷²

⁶⁷ Mercy Corps, "Quick facts: Venezuela's humanitarian crisis", accessed 10 June, 2020, <https://www.mercycorps.org/articles/venezuela-crisis-quick-facts>

⁶⁸ "Introduction" in "The Collapse of Venezuela. The Failed Policies That Drove the Country to Disaster", *Foreign Affairs*, November 12, 2019, <https://www.foreignaffairs.com/articles/venezuela/2019-11-12/introduction>

⁶⁹ Anastasia Moloney, "As Venezuela's healthcare collapses, pregnant women, girls bear brunt of crisis", *Reuters*, July 2019, <https://www.reuters.com/article/us-venezuela-health-women/as-venezuelas-healthcare-collapses-pregnant-women-girls-bear-brunt-of-crisis-idUSKCN1U32AS>

⁷⁰ "Venezuelans with transplants live in fear as medicine runs out", *Reuters*, February 21, 2018, <https://nypost.com/2018/02/21/venezuelans-with-transplants-live-in-fear-as-medicine-runs-out/>

⁷¹ Coordination Platform for Refugees and Migrant Response, "Plan for Refugees and Migrants from Venezuela, January -December 2019", January-December 2019.

⁷² Mercy Corps, "Quick facts: Venezuela's humanitarian crisis", accessed 10 June, 2020, <https://www.mercycorps.org/articles/venezuela-crisis-quick-facts>

By 2019, almost 10% of the Venezuelan population has migrated or sought refugee status in different parts of the world.⁷³ According to the Regional Coordination Platform for the Response for Venezuelans (R4V), as of June of 2020, “(...) 5.1 million Venezuelans were living abroad, 4.3 million of whom were in other Latin American and Caribbean countries”⁷⁴. Colombia hosts the largest number of Venezuelan immigrants, with 1.6 million, including pendular immigrants, who don’t stay permanently in the country. According to the Migration Policy Institute during the last 5 years Venezuelan immigration “(...) constitutes one of the largest forced migration flows anywhere in the world, not far behind that of Syrians in overall numbers.”⁷⁵ Even if Colombia has significant high numbers of Venezuelan asylum seekers, other countries of Latin America have received higher numbers.⁷⁶ According to the Migration Policy Institute, until recently Venezuelans in Colombia have not applied massively for asylum as this would not grant permission to work. However, this situation changed in January of 2020, when the Colombian government started to provide work permits to asylum seekers, and consequently, the numbers started to rise.⁷⁷ Even if Colombia recognizes the 1984 Cartagena Declaration, the country does not necessarily accept the refugee definition “(....) those fleeing generalized violence and the breakdown of public order”

⁷³ Ibid.

⁷⁴ Diego Chaves-González and Carlos Echevarria-Estrada, “Venezuelan Migrants and Refugees in Latin America and the Caribbean. A Regional Profile”, *Migration Policy Institute*, August, 2020, 3.

⁷⁵ Ibid.

⁷⁶ Andrew Selee Jessica Bolter, “An Uneven Welcome. Latin American and Caribbean Responses to Venezuelan and Nicaraguan Migration”, *Migration Policy Institute*, February 2020, 26.

⁷⁷ Ibid.

as it is established by the Declaration.⁷⁸ In Latin America, only Mexico and Brazil have used the broader 1984 declaration refugee definition to analyze the asylum applications of Venezuelans.⁷⁹

The Migration Policy Institute has described three groups of Latin American and Caribbean countries “that attract different migrant profiles and in which refugees and migrants describe different living conditions”⁸⁰. These categories are: i) Countries that share frontiers with Venezuela, including Brazil, Colombia, Guyana, and Trinidad and Tobago; ii) Countries that are close but do not share a frontier, including Peru and Ecuador; and iii) countries that are far away in Latin America and are receiving high numbers of migrants such as Argentina, Chile, Paraguay, and Uruguay and Costa Rica.⁸¹ Venezuelan immigrants in neighbor countries, such as Colombia, tend to have lower education, they are young and single, and report more restricted access to health services and mental-health support.⁸² Also, 17 per cent of Venezuelans in Colombia are pendular immigrants who have reported their desire to return to Venezuela or to immigrate to another country in Latin America.⁸³ In the case of Peru and Ecuador, most Venezuelan immigrants have vocational education or a higher degree and are part of the job market. Finally, Venezuelans in the southern cone tend to have higher education, including college and graduate education, report that they want to stay there permanently and have mostly migrated using regular ways.⁸⁴

⁷⁸ Ibid.

⁷⁹ Ibid, 24.

⁸⁰ Diego Chaves-González and Carlos Echevarria-Estrada, “Venezuelan Migrants and Refugees in Latin America and the Caribbean. A Regional Profile”, *Migration Policy Institute*, August, 2020, 2.

⁸¹ Ibid.

⁸² Ibid.

⁸³ Ibid.

⁸⁴ Ibid.

By 2020, 57 per cent of all Venezuelan immigrants in Colombia had an undocumented status.⁸⁵ Many have crossed the border using formal and informal ways, through the countries' lengthy fluvial and terrestrial borders. This can include Venezuelans that work in Colombia but live in Venezuela, which implies that they walk for many hours each day in order to get the daily minimum sustenance.⁸⁶ Only 37% have a Special Stay Permit, which was specifically created in 2017 to handle the Venezuelan massive migration wave.⁸⁷ This special permit cover Venezuelans who had entered Colombia with a passport before July 28, 2017 and November 29, 2019.⁸⁸ According to the Migration Policy Institute, from all countries in Latin America, Colombia is the country where the largest share of immigrants declared "no particular immigration status".⁸⁹ Being undocumented creates different problems for Venezuelans. Even if Colombia has kept a "flexible migration order" and frontiers are easily permeable, without a regular immigration status Venezuelans are not easily formally employed and cannot access many basic services regular immigrants can access. This is reflected in bad living conditions and extreme poverty.

⁸⁵ "Labour reality of Venezuelans in Colombia", *El Tiempo*, February 26, 2020, <https://www.eltiempo.com/economia/sectores/realidad-laboral-de-venezolanos-en-colombia-466664>

⁸⁶ "Pendular Migration, another one of the variables in the Colombian-Venezuelan migration", *Sectorial*, May 13, 2020, <https://www.sectorial.co/articulos-especiales/item/320785-migraci%C3%B3n-pendular.-otra-de-las-variables-en-la-relaci%C3%B3n-colombia-venezuela>

⁸⁷ Andrew Selee and Jessica Bolter, "An Uneven Welcome. Latin American and Caribbean Responses to Venezuelan and Nicaraguan Migration", *Migration Policy Institute*, February 2020, 15.

⁸⁸ Ibid.

⁸⁹ Diego Chaves-González and Carlos Echevarria-Estrada, "Venezuelan Migrants and Refugees in Latin America and the Caribbean. A Regional Profile", *Migration Policy Institute*, August, 2020.

In terms of their living conditions, according to data from IOM collected between January and December of 2019, 91 per cent of Venezuelans in Colombia lacked financial resources; 46 per cent didn't have access to food; 31 per cent didn't have a place to sleep; 48 per cent lacked transportation; 28 per cent lacked safety; 31 per cent reported issues with migration documents; 56 per cent didn't have access information about services and immigration; only 21 per cent had access to health and 2 per cent have reported arrests.⁹⁰ Furthermore, undocumented Venezuelans were reported to work 50 extra hours per week and earn significantly less, compared to the average of working hours and wages in Colombia.⁹¹ Also, by 2020, 75 percent of undocumented Venezuelan immigrants were dedicated to informal jobs, which can be defined as paid jobs that are not registered, regulated or protected by legal or regulatory frameworks.⁹² Some of these jobs included street sales, cleaning services, and hairdressers; jobs in restaurants, bars, hotels, and transportation; and activities such as domestic work and sex work.⁹³

Bad living situations put undocumented immigrants at a high risk of violence and different forms of exploitation. Women and children have been particularly affected by the process of

⁹⁰ Ibid. Authors' tabulation of IOM data from the DTM, collected between January and December 2019, and shared with Migration Policy Institute.

⁹¹ Ibid.

⁹² "Informal job", International Labour Organization, accessed 30 June, 2020, <https://www.oitcinterfor.org/en/taxonomy/term/3366>

⁹³ Andrés Octavio Cardona, "What are the areas in which Venezuelans who migrate to Colombia work the most?", *La Republica*, February, 2019, <https://www.larepublica.co/consumo/cuales-son-las-areas-en-las-que-mas-trabajan-los-venezolanos-que-migran-a-colombia-2826030>. Also see: "From cutting hair to turning tricks. Venezuelans sell sex in Colombia to survive", *The Economist*, June of 2017, <https://www.economist.com/the-americas/2017/07/20/venezuelans-sell-sex-in-colombia-to-survive>

migration, considering their situation in Venezuela and the circumstances that they must face when they get to Colombia for temporary purposes or permanent residency. As of 2019, two per cent of Venezuelan women abroad between 15 and 49 years of age are survivors of sexual violence.⁹⁴ Sexual violence against Venezuelans includes the exchange of money, goods or services for sex, sexual exploitation and trafficking, and violence exercised by power groups as part of political and civil oppression in Venezuela.⁹⁵ According to “El País” newspaper, from 2017 until September of 2019, 120 Venezuelan women were killed in foreign countries and Colombia was reported as the country with more cases. The reported cases of femicides involved domestic and sexual violence, trafficking and slavery, psychological violence, suicide, sex and labor exploitation, accidents during the process of migration, discrimination, and xenophobia.⁹⁶ Venezuelans don’t tend to seek for protection from the justice system, as there is a generalized lack of protection from the recipient state, mistrust of the governmental institutions in Colombia, and many have fear of deportation.⁹⁷

To understand better the situation of undocumented immigrants it is important to address the negative social perception of this group of people.

⁹⁴ Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar*. (Bogota: IPPF, 2019), 29, <https://profamilia.org.co/wp-content/uploads/2019/05/Evaluation-of-the-sexual-and-reproductive-health-needs.pdf>

⁹⁵ Equivalencias en Acción, *Women on the edge 2019: Women’s rights in the face of the complex humanitarian emergency in Venezuela*. (Caracas: Amnesty International, 2019).

⁹⁶ Ibid.

⁹⁷ Diego Battistessa, “Silent massacre: dead Venezuelans abroad”, *El País*, September 3, 2019, https://elpais.com/elpais/2019/09/02/planeta_futuro/1567434636_760205.html

2.1.4 Perception of undocumented immigrants

Undocumented immigrants usually face different types of xenophobia and discrimination.⁹⁸ This type of discrimination is based on negative perceptions of undocumented immigrants that include “(...) attitudes of fear and mistrust, accusation of criminality and insecurity.”⁹⁹ Understanding this kind of discrimination is relevant for the purposes of this thesis, as this generalized social perception usually permeates the health care system, and can have an impact on the undocumented immigrants’ transit through the health care system.

Sentiments of discrimination against undocumented immigrants have been particularly fueled by governments’ use of terms such as “illegals,” “illegal aliens,” and “non-citizens”.¹⁰⁰ This perception has increased over time and the negative sentiments have become more common after events such as 9/11.¹⁰¹ In the United States, in the context of the war against terrorism and the push for immigration reform, politicians have positioned the idea of undocumented immigration as a threat and an invasion to the “American” culture.¹⁰² Particularly, undocumented immigrants tend to be perceived as mostly Latinx. Therefore, it is common to find generalizations as “all Mexicans are illegal” or “all Hispanics are undocumented”.¹⁰³ Moreover, Latinx, and specially Mexicans, tend to be associated with negative images as “criminals”, “gang members”, “drug dealers” and

⁹⁸ Samuel Wolbert, “Universal healthcare and access for undocumented immigrants”, *PITT. J. ENVTL. & PUB. HEALTH L*, 5 no 61(2011): 61-79, 63.

⁹⁹ *Ibid.*

¹⁰⁰ *Ibid.*

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*, 319.

¹⁰³ *Ibid.*, 321.

“rapists”.¹⁰⁴ These ideas were specially reinforced by Donald Trump during the 2016 elections in the United States.¹⁰⁵ In the case of Venezuelan undocumented immigrants in Colombia, the association with criminality and violence is also common. Venezuelan undocumented immigrants tend to be labeled as “thieves” and “murderers”.¹⁰⁶ Another common stereotype against Venezuelan women in Colombia is the perception that all of them are dedicated to sex work, and therefore are “easy” and a “threat” for men.¹⁰⁷

Moreover, narratives about undocumented immigrants include anxieties about resource distributions. Brietta Clark describes the narrative constructed towards undocumented immigrants as an ““Us-Them” dichotomy” and ““outsiders” that reassure them that they are “insiders.”¹⁰⁸ This narrative consists on differentiating and labeling undocumented immigrants as a burden on the host country who want to take advantage of the host country’s services.¹⁰⁹ This includes welfare policies, medical services, schools and social services, provided for the country’s

¹⁰⁴Ibid, 321- 322.

¹⁰⁵ Michael Schaub, ‘Xenophobia’ is the word of the year for 2016, says Dictionary.com”, *Los Angeles Times*, November 28, 2016, <https://www.latimes.com/books/la-et-jc-xenophobia-word-of-the-year-20161128-story.html>

¹⁰⁶“Venezuelan Migration A Growing Concern for Colombia”, *GLOBSEC*, March, 2018, <https://www.globsec.org/2018/03/20/venezuelan-migration-concern-colombia/>

¹⁰⁷ Joshua Collins, “Why you don’t want to be a Venezuelan woman right now”, *The New Humanitarian*, 27 September, 2019, <https://www.thenewhumanitarian.org/news-feature/2019/09/17/Venezuela-femicide-maternal-mortality-rates-rising>

¹⁰⁸ Janet L. Dolgin & Katherine R. Dieterich, “When Others Get Too Close: Immigrants, Class, and the Health Care Debate”, *Cornell J. L. & Pub. Pol’y* 19 (2010): 283-334,316.

¹⁰⁹ Ibid, 317.

citizens.¹¹⁰ This narrative portrays undocumented immigrants as people who are “eating up resources” that belong to citizens and, in many cases, are very limited to certain people in the country.¹¹¹ Furthermore, undocumented immigrants in the United States are perceived as competing “(...) for jobs and social resources. They are blamed for low wages, for taking jobs from Americans, for stealing taxpayer money, and generally “for the shape of our economy”¹¹².

The burden narrative tends to be deeper in communities that have unsatisfied needs or live in contexts of inequality and poverty. This is especially true for Venezuelans in Colombia, a middle-income country that still has areas of poverty. Historically, frontier cities between Colombia and Venezuela have been affected by Colombian armed groups and other social problems, including profound social and economic gaps.¹¹³ This context fuels the narratives of Venezuelans taking advantage of the Colombian state’s limited resources and the arrival of undocumented immigrants tends to be seen as an accelerator for economic and social crisis.¹¹⁴ These anxieties are being exacerbated by the common phenomenon of Venezuelans having many kids despite extreme poverty. In June of 2019 a widely known columnist wrote an article for the

¹¹⁰ Brietta R. Clar, “The immigrant health care narrative and what it tells us about the U.S. health care system”, *Ann. Health L.* 229 no 17 (2008): 229-277.

¹¹¹ Janet L. Dolgin & Katherine R. Dieterich, “When Others Get Too Close: Immigrants, Class, and the Health Care Debate”, *Cornell J. L. & Pub. Pol’y* 19 (2010): 283-334, 311.

¹¹² *Ibid*, 316.

¹¹³ Mercy Corps, “Quick facts: Venezuela’s humanitarian crisis”, August 13, 2019, <https://www.mercycorps.org/articles/venezuela-crisis-quick-facts>. Frontier cities have higher rates of unemployment, by almost five percentage points higher than the national average, and the informality rate in employment amounts to 80%.

¹¹⁴ *Ibid*.

most prestigious newspaper in Colombia asking Venezuelan women to “stop having children”.¹¹⁵ The columnist argued that due to the twenty thousand babies of Venezuelan parents that have been born in Colombia during the last two and a half years, the Government must make birth control a migration strategy.¹¹⁶ Opinions such as these have generated a public debate around the distribution of resources for Venezuelans and Colombians and the sustainability of health care measures in a crisis that doesn’t seem to have a proximate solution.

2.2 Advocacy for what?

The general goal of physician advocacy is to promote the physical and mental health of undocumented immigrants. Specific objectives of advocacy include: i) To remove obstacles to health care access; ii) To remove obstacles that prevent undocumented immigrants from successfully navigating the health care system and receiving effective care; and iii) To remove obstacles to the physical and mental health of undocumented immigrants due to immigration laws and policies such as detention and family separation. In order to explain these three objectives, it is necessary to identify the current barriers that undocumented immigrants face in the context of their health care in the United States and Colombia.

¹¹⁵Claudia Palacio, “Dejen de parir”, *El Tiempo*, June, 2019, <https://www.eltiempo.com/opinion/columnistas/claudia-palacios/paren-de-parir-columna-de-claudia-isabel-palacios-giraldo-374742>.

¹¹⁶ Ibid.

The American Institute of Medicine and Health defines *health care access* as “the timely use of personal health services to achieve the best possible health outcomes.”¹¹⁷ In this line, the understanding of *health care access* cannot be limited to the admission and use of health services, as it involves the accomplishment of “the best possible health outcomes.”¹¹⁸ Then, this definition should contemplate: i) the coverage of health insurance; ii) the actual admission to health services, including preventive and emergency medical services; iii) the ability to provide timely appropriate services after a need is identified; and iv) workforce capacity that refers to the adequate distribution of qualified health staff and the capacity to provide culturally appropriate services.¹¹⁹ In this chapter, I use this definition of health care access and discuss these four elements in the first two objectives. When I refer to “remove obstacles to health care access” I will be discussing the difficulties related to health insurance coverage and the admission to health services. When I discuss physician advocacy to “remove obstacles that prevent immigrants from successfully navigating the health care system and receiving effective care” I will be considering the elements of timeliness and workforce that generate situations of discrimination against undocumented immigrants. Also, in this category I will be discussing elements related with the quality of care that guarantee the best health results.

¹¹⁷ Institute of Medicine, et al. *Access to Health Care in America*, edited by Michael Millman, (Washington, DC: National Academy Press, 1993), 33.

¹¹⁸ Ibid.

¹¹⁹ Agency for Healthcare Research and Quality, “Chartbook on Access to Health Care”, accessed 20 of April, 2021, <https://www.ahrq.gov/research/findings/nhqrdtr/chartbooks/access/elements.htm> Also see: Healthy People 2020, “Access to Health Services”, accessed 20 April, 2021, <http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>

2.2.1 Advocacy to remove obstacles to health care access for undocumented immigrants in the United States and Colombia

Undocumented immigrants usually lack access to health insurance, which leaves many of them with restricted access to health services. These obstacles can potentially cause them many health complications, as they don't have access to preventive care and, in cases where they have severe conditions, they are left with very few treatment options. Lack of insurance also leaves physicians with the dilemma of disclosing all treatment options properly to immigrants with chronic diseases even when those options won't be available for them.¹²⁰ In other cases, when patients have a chronic or terminal condition, physicians and patients face the challenges of medical repatriation.¹²¹

The process of immigration from Central American countries to the United States and from Venezuela to Colombia usually includes difficult circumstances, including risk of violence from armed groups, sexual violence, overcrowding spaces, settlements in peripheral areas with insufficient hygiene and lack of access to basic sanitation and water.¹²² Many women that cross the Mexican border to the United States have experienced sexual violence. According to Amnesty International, sexual violence is usually used as a way to threat and terrorize women. Then, "Many

¹²⁰ Shamsher Samra, Breena R. Taira, Erika Pinheiro, et al, "Undocumented Patients in the Emergency Department: Challenges and Opportunities", *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798.

¹²¹ Mark Kuczewski, "Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients", *The American Journal of Bioethics*, 19 no 4 (2019): 51-57.

¹²² Profamilia and the Office of the United States for Disaster Assistance Abroad (OFDA-USAID), *Health inequalities of the migrant population and a Venezuelan refugee in Colombia. How to improve local response within the humanitarian emergency?* (Bogota: Profamilia, 2020), 68.

criminal gangs appear to use sexual violence as part of the “price” demanded of migrants. According to some experts, the prevalence of rape is such that people smugglers may require women to have a contraceptive injection prior to the journey as a precaution against pregnancy resulting from rape.”¹²³ This situation is not that different from Venezuelan women that informally cross the borders to get to Colombia.¹²⁴ These migration transits can involve the risk of death due to situations such a “(...) drowning, dehydration, motor vehicle accidents, and violence from law enforcement.”¹²⁵ Moreover, the precarious conditions of the health systems in many Central American countries and Venezuela have an impact on the health condition of immigrants. Considering this, it is essential to understand how immigration status impacts health indicators of undocumented immigrants.¹²⁶ In both countries, health situations can become worse when undocumented immigrants don’t have access to proper health care in the recipient countries.

¹²³ Shamsher Samra, Breena R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798, 794, citing “Invisible Victims on the Move in Mexico”, (Amnesty International: London, 2010), 15.

¹²⁴ Profamilia and the Office of the United States for Disaster Assistance Abroad (OFDA-USAID), *Health inequalities of the migrant population and a Venezuelan refugee in Colombia. How to improve local response within the humanitarian emergency?* (Bogota: Profamilia, 2020).

¹²⁵ Shamsher Samra, Breena R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798, 794.

¹²⁶ Human Rights Watch, “Venezuela: Numbers Highlight Health Crisis Disease Outbreaks; Lives at Risk”, November 15, 2018, <https://www.hrw.org/news/2018/11/15/venezuela-numbers-highlight-health-crisis>

2.2.1.1 Barriers to access health care for undocumented immigrants in the United States

Undocumented immigrants in the United States face several barriers to health care access. At the time of writing, rules and regulations prevent undocumented immigrants from accessing any federal subsidized health care services, and only some states have provided funds to cover basic and urgent care for this population.¹²⁷ First, the Patient Protection and Affordable Care Act (PPACA) which came into effect on March 23, 2010 explicitly “prohibited undocumented immigrants from purchasing insurance in the state and federal marketplaces”.¹²⁸ Before PPACA, undocumented immigrants made up 20 per cent of the total of uninsured populations in the United States.¹²⁹ By 2017, “non-citizen U.S. residents, including undocumented individuals and legal permanent residents, make up 7% of the U.S. population but approximately one quarter of the U.S. uninsured population.”¹³⁰ Thus, by 2019, an estimated of 7.1 million undocumented immigrants in the United States don’t have health insurance.¹³¹ As a result of this, undocumented immigrants tend to depend on non-profit free clinics or Emergency Care. The Emergency Medical Treatment and Active Labor Act (EMTALA) requires health institutions to provide services to screen and

¹²⁷ Rachel E. Fabi, “Public Health in the Context of Migration: Ethics Issues Related to Immigrants and Refugees” in Anna C. Mastroianni, Jeffrey P. Kahn, and Nancy E. Kass, *The Oxford Handbook of Public Health Ethics*, (Oxford University Press, 2018).

¹²⁸ Rachel E. Fabi, “Why Physicians Should Advocate for Undocumented Immigrants’ Unimpeded Access to Prenatal Care”, *AMA Journal of Ethics* 21, no 1(January 2019): E93-99.

¹²⁹Shamsher Samra, Breena R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798.

¹³⁰ Ibid, 791.

¹³¹ Cheng YJ, Kanaya AM, Araneta MRG, et al, “Prevalence of diabetes by race and ethnicity in the United States, 2011-2016.”, *JAMA* 322 (2019): 2389-98.

stabilize patients in the context life-threatening conditions, regardless of their insurance status and without inquiring about immigration status.¹³² It is necessary to note that this mandate remains unfunded and causes many administrative and funding difficulties for emergency hospitals.¹³³ Undocumented immigrants' dependency on emergency services certainly has consequences for their health.¹³⁴ They usually have to access routine dialysis, hemodialysis and other life sustaining treatments using emergency services.¹³⁵ Even when they get admitted into emergency services, they access them in a lower rate than other populations. According to Shamsheer Samra and colleagues, even if there is not enough data about undocumented immigrants' health access, it can be said that they represent less expenditure than other populations.¹³⁶

Despite the federal restrictions that block undocumented immigrants from health insurance coverage, states have made exceptions and designated funds to cover children's and maternal health. States like California have tried to lessen the impact of federal restrictions. In 2015-106 California, home for 2.5 million undocumented immigrants, passed the *Health for All Kids Act*, which offers "(...) insurance coverage to undocumented-immigrant children"¹³⁷. Furthermore,

¹³² Mark Kuczewski, "Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients", *The American Journal of Bioethics*, 19 no 4 (2019): 51-57.

¹³³ American College of Emergency Physicians, "EMTALA fact sheet", accessed 29 March, 2021, <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/>

¹³⁴ Shamsheer Samra, Breena R. Taira, Erika Pinheiro, et al, "Undocumented Patients in the Emergency Department: Challenges and Opportunities", *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798.

¹³⁵ Ibid.

¹³⁶ Ibid, 792.

¹³⁷ Rachel Fabi and Brendan Saloner, "Covering Undocumented Immigrants — State Innovation in California", *Engl j med* 375 no 20 (Nov 2016): 1913-1915, 1913.

Californian legislation has allowed undocumented- immigrant adults to participate in the state exchange and access health insurance funded by the state.¹³⁸ Still, 39 per cent of undocumented immigrants in California “lack a usual source of healthcare” and depend on the emergency department.¹³⁹ Likewise, 18 states and the District of Columbia provide public insurance to pregnant undocumented immigrants.¹⁴⁰ Rachel Fabi explains how some states have found a way to cover maternal health by protecting the “unborn child” of undocumented immigrants, which have protection under the federal Children’s Health Insurance Program (CHIP).¹⁴¹ In the case of New York, New Jersey and the District of Columbia, pregnant undocumented women can get Medicaid benefits with the state-only funds part of the program.¹⁴²

Second, the Public Charge Rule has also affected the access of undocumented immigrants to health care. According to this rule, in the process of applying for green cards or visas “(...) an immigration officer must decide whether that person is likely to become dependent on certain government benefits in the future, which would make them a “public charge”¹⁴³. In 2019, the

¹³⁸ Ibid.

¹³⁹ Shamsher Samra, Breena R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798,792.

¹⁴⁰ Rachel Fabi, “Why Physicians Should Advocate for Undocumented Immigrants’ Unimpeded Access to Prenatal Care” *AMA Journal of Ethic* 21 no 1 (January 2019): E93-99.

¹⁴¹ Henry J. Kaiser Family Foundation, “Where are states today? Medicaid and CHIP eligibility levels for children, pregnant women, and adults”, accessed June 8, 2020, <https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid- and-chip/>.

¹⁴² Rachel Fabi, “Why Physicians Should Advocate for Undocumented Immigrants’ Unimpeded Access to Prenatal Care” *AMA Journal of Ethic* 21 no 1 (January 2019): E93-99, 94.

¹⁴³ Immigrants Legal Center Resource, “Public Charge”, accessed 8 August, 2020, <https://www.ilrc.org/public-charge>

Trump administration added new federally-funded Medicaid, federally supported public housing and food stamps as benefits that immigration officers could use to argue someone is placing a “public charge” as a reason to deny visa applications, making immigrants afraid of accessing benefits that they had been accessing before.¹⁴⁴ On July of 2020, New York U.S. District Judge George Daniels blocked the new “public charge” immigration restriction, considering the impacts the rule was having on immigrants’ access to COVID-19 medical and basic services.¹⁴⁵ According to the Judge, “As a direct result of the rule, immigrants are forced to make an impossible choice between jeopardizing public health and personal safety or their immigration status (..)”¹⁴⁶ Even after this rule was blocked during the COVID-19 emergency, its effects continued to be felt. Many immigrants disenrolled from the “Supplemental Nutritional Assistance Program -SNAP-” and did not seek to access health care as they are afraid that depending on this kind of programs might have a negative effect on their immigration status.¹⁴⁷ This and other “anti-immigration” measures created a “chilling effect” which increases immigrant’s lack of trust in health institutions and prevents many of them from seeking medical attention which results in the delay of attaining

¹⁴⁴ Ibid.

¹⁴⁵ Nicole Narea, “A federal judge blocked Trump’s rule creating a wealth test of immigrants”, *Vox*, July, 30, 2020, <https://www.vox.com/policy-and-politics/2019/10/11/20899253/trump-public-charge-rule-immigrants-welfare-benefits>

¹⁴⁶ “Judge blocks public charge restrictions due to the pandemic”, *CWLA*, July 29, 2020, <https://www.cwla.org/judge-blocks-public-charge-restrictions-due-to-pandemic/>

¹⁴⁷ Kathleen Page, Maya Venkataramani, et al, “Undocumented U.S. Immigrants and Covid-19, *N engl j med* 382, no 21(2020), E621.

medical attention out of fear of deportation.¹⁴⁸ According to a 2020 survey of immigrants in Texas, “11.6% of respondents (corresponding to over 400,000 low-income citizens statewide) reported knowing friends or family who had avoided participating in Medicaid, SNAP, or public housing, or had not visited a physician or hospital because of immigration-related concerns in the previous year. Eight percent had avoided medical care, with smaller numbers avoiding Medicaid (2.9%), SNAP (3.5%), and public housing (2.4%).”¹⁴⁹ This is highly relevant in the context of the COVID-19 pandemic, as many immigrants are afraid of seeking care or being tested for the fear of being deported and the confusion generated by the blocked Public Charge Rule.¹⁵⁰ In 2020, the government established that “(...) it will not consider COVID-19 testing, treatment, or preventive care, including a vaccine if one becomes available, as part of the public charge test.”¹⁵¹

Finally, other immigration measures such as raids and massive deportations have pushed many immigrants away from the health care system. According to Karen Hacker and colleagues, the fear around ICE has negative impacts on either health or health care access as it has led to

¹⁴⁸ Mark Kuczewski, “Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients”, *The American Journal of Bioethics* 19 no 4 (2019): 51-57, 52.

¹⁴⁹ Benjamin D. Sommers, Heidi Allen, Aditi Bhanja, et al, “Assessment of Perceptions of the Public Charge Rule Among Low-Income Adults in Texas”, *JAMA Network Open*, 3 no 7 (Jul 2020): 1-5.

¹⁵⁰ Jose Figueroa, “The Trump administration’s ‘public charge’ rule and Covid-19: bad policy at the worst time”, *State News*, August 21, 2020, <https://www.statnews.com/2020/08/21/the-trump-administrations-public-charge-rule-and-covid-19-bad-policy-at-the-worst-time/>

¹⁵¹ Immigrant Legal Center Resource, “Public charge. Outreach Toolkit”, accessed 15 July, 2020, https://www.ilrc.org/sites/default/files/resources/2020.09_ilrc_public_charge-what_community_needs_to_know_0.pdf

undocumented immigrants interrupted care.¹⁵² She mentions how concerns about ICE and fears around deportation make many undocumented patients stop necessary treatments for chronic diseases, interrupt or cancel dialysis and HIV treatments and don't show up at follow up visits and Well Child appointments.¹⁵³ In the same line, Mark Kuczewski and Kathleen R. Page have described how the “chilling effect” causes immigrants to avoid services or to be fearful when they try to access health services. Page shares a story of an undocumented pregnant immigrant in Baltimore who was diagnosed with syphilis and was asked to go back to the hospital for treatment. When she saw a security guard she left as she did not have papers and was fearful of being arrested.¹⁵⁴ This fear is not unfounded, as in many cases immigration authorities learn about the immigration status of patients and have arrested them in the hospitals. In September of 2020, ICE arrested and reported a 15-year-old undocumented immigrant at Edinburg hospital in Texas.¹⁵⁵ In this case, the Customs and Border Protection (CBP) officials waited until she had a procedure done and then arrested her in order to deport her back to Mexico.¹⁵⁶ Altaf Saadi reports a common trend in which ICE agents arrest undocumented immigrants near hospitals and other health care

¹⁵² Karen Hacker, Jocelyn Chu, Lisa Arsenault, et al, “Provider’s Perspectives on the Impact of Immigration and Customs Enforcement (ICE) Activity on Immigrant Health”, *J Health Care Poor Underserved* 23 no 2 (May, 2012):1-13.

¹⁵³ Ibid, 6.

¹⁵⁴ Kathleen R. Page and Sarah Polk, “Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families” *N engl j med* 376 no 12 (March 2017): e20(1)- e20(3).

¹⁵⁵ Camilo Montoya, “15-year-old girl who spent her life in the U.S. facing deportation after hospital arrest”, *CBS News*, September 25, 2020, <https://www.cbsnews.com/news/15-year-old-girl-who-spent-her-life-in-the-u-s-facing-deportation-after-hospital-arrest/>

¹⁵⁶ Ibid.

facilities.¹⁵⁷ Many immigrants are arrested waiting for surgeries or medical procedures and during their recovery.¹⁵⁸ In these type of situations, physicians are caught between the demands of the practice of medicine and immigration policies, like when they have to question patients “(..) about their immigration status and report (suspected) undocumented immigrants to the authorities.”¹⁵⁹ Apart from creating a climate of mistrust among undocumented patients, this can also cause moral distress and affect physicians’ moral integrity as they might feel they are undermining their professional integrity.¹⁶⁰

The fear around deportation and confidentiality violations can be significantly increased or reduced by hospitals and clinics “front door policies.”¹⁶¹ Brietta Clark shows how some hospitals choose to use strong front door policies in order to prevent immigrants from receiving their services. She provides examples about Texas and New York Hospitals that use measures such as asking their security guards to dress similar to immigration authorities or request their staff to explicitly ask immigration information in order “to discourage uninsured and undocumented immigrant patients in the United States from seeking care.”¹⁶² Apart from front doors policies,

¹⁵⁷ Altaf Saadi, Sameer Ahmed, Mitchell H. Katz, “Making a Case for Sanctuary Hospitals” *JAMA*, 318 no 21 (2017): 2079-2080.

¹⁵⁸ Ibid.

¹⁵⁹ Mark R. Wicclair “Ethics case. Positive Claims of Conscience and Objections to Immigration Law”, *American Medical Association Journal of Ethics* 15 no 3(March 2013): 188-192, 190.

¹⁶⁰ Ibid.

¹⁶¹ Altaf Saadi, Sameer Ahmed, Mitchell H. Katz, “Making a Case for Sanctuary Hospitals” *JAMA*, 318, No 21(2017): 2079-2080.

¹⁶²Brietta R. Clark, “The immigrant health care narrative and what it tells us about the U.S. health care system”, *Ann. Health L.* 229 no 17 (2008): 229-277, 229.

some hospitals have reported undocumented patients to immigration authorities.¹⁶³ Likewise, physicians and hospitals face the question of when to discharge an undocumented patient if there are not available treatments and continuing to provide care will place a heavy economic burden on the institution.¹⁶⁴ In some cases, hospitals have used the practice of “repatriation” which means returning a sick immigrant to their home country when they face chronic or terminal conditions.¹⁶⁵ This raises a difficult ethical question as in many cases there is not clear consent or patients and their families end up accepting this measure “(...) because they are told they have no options; sometimes they are grateful to the hospital for paying their fare home, given that other hospitals leave it to relatives or consulates to assume responsibility for the patients.”¹⁶⁶ On the contrary, other hospitals have eliminated their front door policies in order to make their services friendlier for undocumented immigrants.

Overall, the restrictions to health care access cause direct effects in undocumented immigrants’ health. They bear “(...) a disproportionate burden of undiagnosed illness-including communicable diseases such as tuberculosis and HIV-and frequently lack basic preventive care

¹⁶³ Dorothy L. Pennachio, “What Would You Do? In This Border-Town Dilemma”, *Medical Economics*, June 18, 2004, http://medicaleconomics.modernmedicine.com/memag/infectious+Disease/What-would-you-do-brln-this-border-town_dilemma/Article_Standard/Article/detail/108972. Also see: Deborah Sontag, “Immigrants Facing Deportation by U.S. Hospitals”, *New York Times*, August 3, 2008, <https://www.nytimes.com/2008/08/03/us/03deport.html>

¹⁶⁴ Janet L. Dolgin & Katherine R. Dieterich, “When Others Get Too Close: Immigrants, Class, and the Health Care Debate”, *Cornell J. L. & Pub. Pol’y* 19 (2010): 283-334.

¹⁶⁵ Ibid, 288- 293.

¹⁶⁶ Deborah Sontag, “Immigrants Facing Deportation by U.S. Hospitals”, *New York Times*, August 3, 2008, <https://www.nytimes.com/2008/08/03/us/03deport.html>

and immunizations.”¹⁶⁷ According to the CDC, the main causes of death and illness in the Latinx community are heart disease, cancer, injuries, diabetes and obesity.¹⁶⁸ Even if not all Latinx are undocumented immigrants, this information is significant as the majority of undocumented immigrants are from Latin American countries.¹⁶⁹ Likewise, undocumented immigrants are more likely to experience reproductive and maternal health complications. For example, undocumented immigrants are more likely to suffer complications during labor and, comparing with documented Latinx immigrants, their children are more likely to have low birthweight.¹⁷⁰

Health disparities have become evident and worsened with the COVID-19 pandemic. Latinx communities, who represent a high number of undocumented immigrants, are “being infected and hospitalized at up to three times the rate of white Americans”¹⁷¹. For example, by

¹⁶⁷ Jeffrey T. Kullgren, “Restrictions on Undocumented Immigrants’ Access to Health Services: The Public Health Implications of Welfare Reform”, *American Journal of Public Health*, 93 no 10 (October 2003): 1630-1633, 1630.

¹⁶⁸ CDC, “Health of Hispanic or Latino Population”, accessed August 3, 2020, <https://www.cdc.gov/nchs/fastats/hispanic-health.htm>

¹⁶⁹ Julia Gelatt and Jie Zong, “Settling In: A Profile of the Unauthorized Immigrant Population in the United States”, *Migration Policy Institute*, November, 2018, <https://www.migrationpolicy.org/research/profile-unauthorized-immigrant-population-united-states>.

¹⁷⁰ Rachel E. Fabi, “Why Physicians Should Advocate for Undocumented Immigrants’ Unimpeded Access to Prenatal Care”, *AMA Journal of Ethics* 21, no 1 (January 2019): E93-99. Also see: Reed MM, Westfall JM, Bublitz C, Battaglia C and Fickenscher A, “Birth outcomes in Colorado’s undocumented immigrant population”, *BMC Public Health* 5 no 1 (2005):100.

¹⁷¹ Maanvi Singh and Mario Koran, “The virus doesn’t discriminate but governments do’: Latinos disproportionately hit by coronavirus”, *The Guardian*, April 18, 2020, <https://www.theguardian.com/us-news/2020/apr/18/the-virus-doesnt-discriminate-but-governments-do-latinos-disproportionately-hit-by-coronavirus>

April of 2020, New York City Latinx's deaths were reported to be 1.6 times the rate for whites.¹⁷² Likewise, according to a 2020 CDC study, 75 per cent of children that have been affected by COVID-19 are Latinx, black and American Indian.¹⁷³ Out of the total number of minors who have died from COVID-19 from April to July of 2020, 45 percent were Latinx and 75 percent had an underlying condition such as asthma and obesity, which are very common among Latinx communities.¹⁷⁴ Specifically, undocumented immigrants have been very affected by the pandemic as they cannot rely on primary care providers. This has forced undocumented immigrants to depend on online information, seek emergency care, wait too long to seek care or avoid getting any medical care.¹⁷⁵

2.2.1.2 Barriers to access health care for undocumented immigrants in Colombia

Like undocumented immigrants in the United States, Venezuelan undocumented immigrants in Colombia have highly restricted access to health care insurance and they tend to rely on emergency services and international cooperation health initiatives. With the United Nations declaration of a humanitarian emergency in Venezuela in 2018, many international cooperation agencies such as the International Red Cross, The United Nations High Commissioner for Refugees, Caritas International, among others, have arrived in Colombia in order to offer

¹⁷² Ibid.

¹⁷³ William Wan, "Coronavirus kills far more Hispanic and Black children than White youths, CDC study finds", September 15, 2020, *The Washington Post*, https://www.washingtonpost.com/health/2020/09/15/covid-deaths-hispanic-black-children/?fbclid=IwAR2RkgYPTozSxuG0A_gHR-N7iJ_SeA39w3w1_txqyCVRy7xIygewH2iNir0

¹⁷⁴ Ibid.

¹⁷⁵ Kathleen Page, Maya Venkataramani, et al, "Undocumented U.S. Immigrants and Covid-19, *N engl j med* 382, no 21(2020), E621.

services to immigrants, including primary health brigades, shelters and food.¹⁷⁶ However, these services are not enough, as chronic health conditions are very common among Venezuelan undocumented immigrants who tend to require specialist care, which most of them cannot afford.¹⁷⁷ According to the Colombian Health Minister, by 2019, out of the total of Venezuelan immigrants and refugees in Colombia- documented and undocumented- only 5 percent had health insurance.¹⁷⁸ Moreover, immigrants can opt for subsidized or contributive health insurance, only if they are regularly in the country.¹⁷⁹

The Colombian Constitutional Court has considered as a general rule that “(...) all migrant foreigners, including those who are in an irregular situation in the country, have the right to receive basic and emergency care in the national territory”¹⁸⁰. According to the Court allowing immigrants

¹⁷⁶ Coordination Platform for Refugees and Migrant Response, “Plan for Refugees and Migrants from Venezuela, January -December 2019”, 2019. Also see: Profamilia and the Office of the United States for Disaster Assistance Abroad (OFDA-USAID), *Health inequalities of the migrant population and a Venezuelan refugee in Colombia. How to improve local response within the humanitarian emergency?* (Bogota: Profamilia, 2020), 32, <https://www.profamilia.org.co/wp-content/uploads/2020/04/Desigualdades-en-salud-de-la-poblacion-migrante-y-refugiada-venezolana-en-Colombia-Como-manejar-la-respuesta-local-dentro-de-la-emergencia-humanitaria.pdf>.

¹⁷⁷ Ibid.

¹⁷⁸ Profamilia and the Office of the United States for Disaster Assistance Abroad (OFDA-USAID), *Health inequalities of the migrant population and a Venezuelan refugee in Colombia. How to improve local response within the humanitarian emergency?* (Bogota: Profamilia, 2020).

¹⁷⁹ (Translated by the author) Minister of Health and Social Protection of Colombia, “Health sector response to the migratory phenomenon”, 2019, <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COM/plan-respuesta-salud-migrantes.pdf>

¹⁸⁰ (Translated by the author) A foreigner is defined as the “person who is not a national of a specific State, including the stateless person, the asylee, the refugee and the worker migrant”. Decree 1743 of 2015, article 2.2.1.11.4.

to access emergency care “is a minimum essential content of the right to health that seeks to understand that every person in Colombia has the right to a vital minimum, as a manifestation of their human dignity, that is, a right to receive minimal care by the State in cases of [extreme] need and urgency, in order to meet their most elementary and primary needs”¹⁸¹ At this point, it is necessary to highlight that in contrast to the United States, in Colombia there is a constitutional recognition of health as a fundamental right of all people.¹⁸² Moreover, following the constitutional principle of non-discrimination, “all persons” or “all inhabitants of the national territory” are entitled to constitutional rights. Thus, the Constitutional Court has held that fundamental rights cannot be denied on the basis of lack of citizenship.¹⁸³

Since 2016, the constitutional discussion around the health of undocumented immigrants has focused on the definition of an urgency. According to the Colombian legal order, “urgency care” can be defined as a “Modality of provision of health services, which seeks to preserve life and prevent critical, permanent or future consequences, through the use of health technologies for the care of users who present alteration of physical, functional or mental integrity, by any cause and with any degree of severity that compromise their life or functionality”.¹⁸⁴ However, the Constitutional Court has understood that the concept of health urgency care should consider human rights and public health perspectives.¹⁸⁵ Using these perspectives, the Court has opened the

¹⁸¹ (Translated by the author) Constitutional Court of Colombia, ruling C-834 of 2007.

¹⁸² Congress of Colombia, Statutory Act 1751 de 2015.

¹⁸³ Constitutional Court of Colombia, ruling T-210 of 2018.

¹⁸⁴ (Translated by the author) Minister of Health and Social Protection, Resolution 5269 of December 22, 2017, Article 8, number 5.

¹⁸⁵ Constitutional Court of Colombia, Ruling SU-677 of 2017.

spectrum of a medical urgency, stating that using the constitutional principle of solidarity¹⁸⁶ and the parameters of reasonableness and proportionality, it is necessary to activate the necessary care to get the “(...)the realization of the right to health of migrants with higher standards than mere medical emergency, especially in the case of those migrants in a greater situation of vulnerability”.¹⁸⁷ This means that undocumented immigrants have the right to access emergency care that “goes beyond preserving vital signs and can cover care for catastrophic illnesses or the performance of surgeries, as long as their urgency to preserve the condition is proven life and health of the patient”.¹⁸⁸

Specifically, the Constitutional Court of Colombia has created a precedent that recognizes that the Colombian government must cover cancer, HIV and medical treatments for other chronic conditions of undocumented immigrants establishing that “(...) it is reasonable that in some exceptional cases, 'emergency care' [may] even include the treatment of catastrophic diseases such as cancer, when they are requested by the treating physician as urgent and, therefore, are essential and cannot be reasonably delayed without endangering life”.¹⁸⁹ The Court has ordered the coverage of treatments of these conditions “(...) whenever the treating doctor determines that state of need or urgency, that is, it is essential that, by virtue of the criteria of a health professional, who is competent to determine the condition of the patient according to their technical training, the

¹⁸⁶ Ibid.

¹⁸⁷ (Translated by the author) Constitutional Court of Colombia, rulings T-314 of 2016, SU-677 of 2017, T-705 of 2017, T-210 of 2018, T-348 of 2018 and T-197 of 2019.

¹⁸⁸ (Translated by the author) Constitutional Court of Colombia, rulings T-314 of 2016, SU-677 of 2017, T-705 of 2017, T-210 of 2018, T-348 of 2018 and T-197 of 2019.

¹⁸⁹ (Translated by the author) Constitutional Court of Colombia, rulings T-197 of 2019.

procedure to be followed under the protocols established for the matter is verified and ordered.”¹⁹⁰

Thus, physicians have a crucial role in the determination of what constitutes an emergency, under the broad interpretation that the Court has provided, and can determine if undocumented immigrants can access a specific treatment through the concept of emergency care.

Apart from covering urgent care and treatments for chronic conditions, the Colombian Minister of Health has urged the departments and municipalities of Colombia to direct actions of surveillance in public health, vaccination and collective interventions for all Venezuelan immigrants.¹⁹¹ From 2017 to 2018 the Colombian government provided around 348,631 immunizations for Venezuelan immigrants, including undocumented, 86% of these immunizations were provided to children under 5 years old and 5% to pregnant immigrants.¹⁹² Due to propagation of communicable diseases that have been abolished in Colombia such as measles, diphtheria, or others that have not been eliminated such as tuberculosis, malaria and sexually transmitted diseases, especially HIV-AIDS, the different governments of Latin America created a “single regional vaccination card” for Venezuelan immigrants.¹⁹³ This initiative promotes regional

¹⁹⁰ (Translated by the author) Ibid.

¹⁹¹ Ministry of Health and Social Inclusion of Colombia, Circular 25 of July 31 of 2017.

¹⁹² (Translated by the author) Minister of Health and Social Protection of Colombia, “Health sector response to the migratory phenomenon”, 2019, <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COM/plan-respuesta-salud-migrantes.pdf>

¹⁹³ (Translated by the author) Proyecto Migración Venezuela “ Colombia will have a single regional vaccination card for Venezuelan immigrants”, 27 of August, 2019, <https://migravenezuela.com/web/articulo/tarjeta-de-vacunacion-para-migrantes-venezolanos/1441>

coordination to provide immunizations and other preventive and diagnostic measures for chronic diseases that are disproportionately impacting Venezuelan immigrants in the region.¹⁹⁴

Even if the Colombian authorities, and specifically the Constitutional Court, have guaranteed a minimum protection of the health of undocumented immigrants and have made significant efforts to address their health situation, reality is far away from court decisions. An example of this is how health providers have different interpretations of what constitutes a medical emergency, which causes many barriers and, in most cases, undocumented immigrants are charged or are not treated in cases of urgent care.¹⁹⁵ Undocumented immigrants have reported charges for primary care, diagnostic tests, medical supplies or medicines and nutritional supplements.¹⁹⁶ The Constitutional Court of Colombia has studied cases where undocumented immigrants have been denied specific medical attention or medicines that are required for their care, even if this attention could be understood as urgent care. For example, the Court has referred to cases of pregnant women that were denied access to prenatal care and delivery, even when the Constitutional Court has specifically claimed that prenatal care and deliveries are included in the concept of medical urgency, as “(...) pregnancy could lead to adverse physical consequences that deserved immediate attention (....)”¹⁹⁷ During an interview in a study by Profamilia an undocumented immigrant explained ““I know a friend who was going to have a baby here but couldn’t. She had to return to

¹⁹⁴ Ibid.

¹⁹⁵ (Translated by the author) Minister of Health and Social Protection of Colombia, “Health sector response to the migratory phenomenon”, 2019, <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COM/plan-respuesta-salud-migrantes.pdf>

¹⁹⁶ Ibid, 34.

¹⁹⁷ (Translated by the author) Constitutional Court, ruling T- 298 of 2019. Also see: Constitutional Court, ruling SU- 677 of 2017.

Venezuela because she was being charged with 1 million Colombian pesos to have her baby here (...).¹⁹⁸ Furthermore, in many cases, immigrants get to access basic care, but hospitals deny the continuity of treatment, arguing it is no longer urgent care and that they should not cover more than the basic procedures and measures to stabilize a patient. This is the case of chronic conditions as Lupus, HIV and cancer, as undocumented immigrants might be diagnosed but don't get to access the treatment for their recovery.¹⁹⁹

Venezuelan immigrants tend to have several health problems, including high rates of suicides, maternal mortality, respiratory complications, HIV, cervical cancer, health consequences from domestic violence, malnutrition and different vaccine-preventable diseases due to the absence of public health measures in their home country over the last years.²⁰⁰ These difficult health outcomes respond to the precarious health situation in Venezuela, the conditions during the migration process and the barriers to access health care in Colombia. According to the Migration Policy Institute between 5 percent and 15 percent of Venezuelan immigrants in Argentina, Colombia, Ecuador, Guyana, and Peru are “suffering from chronic health conditions between mid-2018 and mid-2019”²⁰¹. Moreover, Venezuelans with chronic health conditions tend to migrate to

¹⁹⁸ Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar* (Bogotá: IPPF, 2019), 65.

¹⁹⁹ Constitutional Court of Colombia, ruling, T-452 of 19.

²⁰⁰ Human Rights Watch, “Venezuela: Numbers Highlight Health Crisis Disease Outbreaks; Lives at Risk”, November 15, 2018, <https://www.hrw.org/news/2018/11/15/venezuela-numbers-highlight-health-crisis>

²⁰¹ Diego Chaves-González and Carlos Echevarría-Estrada, “Venezuelan Migrants and Refugees in Latin America and the Caribbean. A Regional Profile”, *Migration Policy Institute*, August, 2020, 18.

Colombia in order to access specialized care that is currently unavailable in Venezuela.²⁰² For example, during 2019, 1,100 Venezuelan children used medical cancer services in Colombia.²⁰³ Similarly, during the same year, 1,053 Venezuelans used HIV/Aids related health services and the incidence of diabetes among immigrants increased 68.5 percent in relation with the previous year.²⁰⁴ Cancer and other type of chronic conditions among Venezuelan immigrants tend to be detected in advance stages, as the Venezuelan health care system has lacked preventive and diagnostic services for the last 5 years.²⁰⁵ This can lead to considerably worse health outcomes compared to those in the host community.

In terms of maternal care, the health of women is specially affected by immigration dynamics.²⁰⁶ Data from the Minister of Health shows a high impact of maternal mortality, HIV, cervical cancer and insecure abortions among Venezuelan migrants.²⁰⁷ Many Venezuelan women migrate to Colombia in order to access reproductive health services, as they are very deficient in their home country. From 2012 to 2016 maternal mortality in Venezuela increased 66 per cent.²⁰⁸

²⁰² Minister of Health and Social Protection of Colombia, “Health sector response to the migratory phenomenon, 2019”, <https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COM/plan-respuesta-salud-migrantes.pdf>

²⁰³ Ibid.

²⁰⁴ Ibid.

²⁰⁵ Ibid.

²⁰⁶ Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar* (Bogota: IPPF, 2019).

²⁰⁷ Ibid.

²⁰⁸ Equivalencias en Acción, *Women on the edge 2019: Women’s rights in the face of the complex humanitarian emergency in Venezuela*. (Caracas: Amnesty International, 2019), 40-46.

20,000 babies of Venezuelan parents have been born in Colombia during the last two and a half years.²⁰⁹ Also, 8,209 pregnant Venezuelan women were registered entering the country.²¹⁰ Out of this population 76.7 per cent did not have any pre-natal care before entering to Colombia and 98 per cent did not have social security.²¹¹ In “Erasmus Meos” Hospital in Cucuta, one of the biggest public hospitals in a border city with Venezuela, from January to April of 2020, 83,2% of the reported deliveries are from Venezuelan immigrants.²¹²

2.2.2 Advocacy to remove obstacles that prevent undocumented immigrants from successfully navigating the health care system and receiving effective care

When undocumented immigrants get to be admitted into health services, they also face obstacles that prevent them from successfully navigating them and receiving effective care. These barriers include: fear of being reported to immigration authorities, discrimination, xenophobia and language barriers. Moreover, physicians and bioethicists have highlighted challenges that generate obstacles for the proper health care attention of undocumented patients, including the difficulties of providing the best standard of care for undocumented immigrants, as they usually have bad

²⁰⁹ Anastasia Moloney, “As Venezuela's healthcare collapses, pregnant women, girls bear brunt of crisis”. *Reuters*, July 2019, <https://www.reuters.com/article/us-venezuela-health-women/as-venezuelas-healthcare-collapses-pregnant-women-girls-bear-brunt-of-crisis-idUSKCN1U32AS>.

²¹⁰ Marta Maeso, “14 examples of how the crisis in Venezuela affect women the most”, *El País*, August, 2019, https://elpais.com/elpais/2019/08/07/planeta_futuro/1565169579_350421.html

²¹¹ Ibid.

²¹²(Translated by the author) “The drama of Venezuelans to give birth during quarantine”, *Frontera*, May 2, 2020, <https://www.laopinion.com.co/frontera/el-drama-de-las-venezolanas-para-dar-luz-en-la-cuarentena>.

living conditions and lack of safety nets.²¹³ Also, physicians and undocumented patients have to deal with complications related with confidentiality when state laws or local authorities ask professionals to disclose patients' immigration status or collaborate with immigration authorities.²¹⁴ These barriers affect the elements of timeliness and adequate workforce, included in the definition of health care access.

2.2.2.1 Obstacles that undocumented patients face navigating the health system in the United States

In the United States, the immigration policies pushed by former president Donald Trump have had an impact on the way undocumented patients interact with the healthcare system. Immigrants have reported lower quality of care in health services provision, which can be connected to structural barriers of the health care system, language barriers and discrimination and xenophobic attitudes towards undocumented immigrants. When undocumented immigrants get to access health care, their experience can be transformed by the fear and mistrust they face. This has been impacted by the anti-immigration political climate, and it can also be impacted by physicians' individual behaviors and other contextual characteristics.²¹⁵ Specifically, fear or mistrust can be manifested in undocumented immigrants being reluctant to share relevant information with physicians, which can significantly impact the quality of the attention and health treatments they

²¹³ Mark Kuczewski, "Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients", *The American Journal of Bioethics*, 19 no 4 (2019): 51-57.

²¹⁴ Deborah Zion, "On beginning with justice: Bioethics, advocacy and the rights of asylum seekers", *Bioethics, Special Issue: Advocates and Activists* 33 (2019):890–895.

²¹⁵ Kathleen R. Page and Sarah Polk, "Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families" *N engl j med* 376 no 12 (March 2017): e20(1)- e20(3).

receive. This information includes medical relevant facts, data related with their real immigration status, contact information in order to do follow up, among other things. Kathleen R. Page and Sarah Polk explain that undocumented immigrants tend to be “(...) reluctant to interact with staff at public agencies or to enter their information in government data- bases (...).”²¹⁶ Also, undocumented immigrants tend to avoid giving information about their true identity, “(...) which often impacts health (difficult getting old records when patient uses another name).”²¹⁷ Undocumented immigrants’ reluctance to share their information can be impacted by variables such as “(...)privacy, time availability, ambient noise level and other contextual factors [that] are likely to influence what a patient will share, where and when.”²¹⁸

Another obstacle that affect transit of undocumented immigrants in health care is related to stigma and discrimination. Janet L. Dolgin & Katherine R. Dieterich report that some hospitals have failed to provide “(...) appropriate care, including epidurals, for non-English speaking pregnant women”.²¹⁹ Moreover, undocumented immigrants have reported that the stigma around their status affects their interaction with the health system. Many of them have experienced embarrassment or they have expressed “Not wanting to be a burden to society or experiencing shame when seeking services and concerns about being stigmatized when seeking services.”²²⁰.

²¹⁶ Ibid, e20(1).

²¹⁷ Karen Hacker, Jocelyn Chu, et al, “Provider’s Perspectives on the Impact of Immigration and Customs Enforcement (ICE) Activity on Immigrant Health”, *J Health Care Poor Underserved* 23 no 2 (May 2012): 651–665, 657.

²¹⁸ Ibid.

²¹⁹ Janet L. Dolgin & Katherine R. Dieterich, “When Others Get Too Close: Immigrants, Class, and the Health Care Debate”, *Cornell J. L. & Pub. Pol’y* 19 (2010): 283-334, 284.

²²⁰ Karen Hacker’ Maria Anies’ Barbara L Folb, et al, “Barriers to health care for undocumented immigrants: a literature review”, *Risk Management and Healthcare Policy*, 8 (Oct 2015): 175–183, 177.

Discrimination can also be manifested in language barriers and cultural differences, which can significantly impact immigrants' health experience. For example, an HIV study on undocumented Latinx immigrants in the United States shows that many patients have been diagnosed without understanding the implications or treatment. A patient explains: "I was never helped by anyone to help me understand the papers I was signing. I felt lost because I did not have someone to give me information in Spanish. I felt like when I was diagnosed I had no guidance as to other services, and I did not get a clear understanding of what medications to take and what the side effects were."²²¹ Similarity, even when there are interpreters available to Spanish speaking immigrants, physicians tend to lack cultural humility or competency skills. This can be explained as physicians' inability to understand "(...) nuances of another culture and expressing one's problems so that they are understood and not ignored."²²² This can cause immigrants to feel discomfort and misunderstood as they feel they are unable to express their symptoms or fit into the dominant culture.²²³

Overall, undocumented immigrants in the United States face other type of barriers that can make their health care journey less satisfactory and lower the quality of care they receive, which can impact their mental and physical health.

²²¹ Bich N. Dang, Thomas P. Giordan, et al, "Sociocultural and Structural Barriers to Care Among Undocumented Latino Immigrants with HIV Infection", *J Immigrant Minority Health* 14 (2012):124–131.

²²² Karen Hacker, Maria Anies, Barbara L Folb, et al, "Barriers to health care for undocumented immigrants: a literature review", *Risk Management and Healthcare Policy*, 8 (Oct 2015): 175–183 178.

²²³ Ibid.

2.2.2.2 Obstacles that undocumented patients face navigating the health system in Colombia

Unlike the United States, Colombia has a flexible immigration policy which creates a different scenario for undocumented immigrants. Even if fear is not out of undocumented immigrants' life, the Colombian context does not place an emphasis on deportation measures.²²⁴ However, xenophobia and discrimination are very common among health care staff.

Discrimination, xenophobia and stigma against Venezuelan immigrants tend to be common among the Colombian community.²²⁵ This has permeated the health sector, causing immigrants to face different kinds of discrimination when they go to hospitals or clinics. A 2019 research report shows how Venezuelan immigrants that get to access urgency services have felt discriminated against.²²⁶ It is common that they are lied to or that they hear phrases like “Undocumented immigrants come to take advantage of our resources and then should return to their country”²²⁷. Even if Venezuelans speak the same language as Colombians, there are many communication barriers as immigrants usually don't get enough information about how to navigate the complex health care system and about their own health problems.²²⁸

²²⁴ (Translated by the author) Dejusticia, “Citizen intervention in the process T7.071.275”, March 29 of 2019.

²²⁵ Ana León, “Xenophobia against Venezuelans worsens amid the pandemic”, *La Silla Vacía*, April 1, 2020, <https://lasillavacia.com/xenofobia-contra-venezolanos-recrudece-medio-pandemia-76074>

²²⁶ Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar*. (Bogotá: IPPF, 2019), 115.

²²⁷ (Translated by the author) Natalia Arenas, “For Venezuelans, pregnancy is a crossroads”, *Cero Setenta*, December, 2019, <https://cerosetenta.uniandes.edu.co/para-las-venezolanas-el-embarazo-es-una-encrucijada/>

²²⁸ Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar*. (Bogotá: IPPF, 2019), 15.

For example, during obstetric care, Venezuelan undocumented women have reported acts of xenophobia and discrimination from health care workforce.²²⁹ In December of 2019, a newspaper shared the story of a 15 years old undocumented immigrant who was a victim of sexual violence and gave birth in Arauca, a frontier city in Colombia. She suffered severe bleeding from a tear, was denied access to medications during her stay at the hospital and “(..)the doctors told her things like 'here we are doing you a favor' and 'you are so little and pregnant, so don't cry'”.²³⁰

Finally, both in the United States and Colombia the navigation of undocumented immigrants through the health system is affected by the lack of options that providers have to treat them. Doctors have expressed their moral anguish as they cannot provide the same quality of care to undocumented immigrants due to structural problems in the health system, insurance limitations, and immigrants' lack of financial and social support.²³¹ Physicians often face the dilemma of disclosing all treatment options appropriately to immigrants with chronic illnesses, in cases where those options will not be available to them. This is reflected in the case of many immigrants that are diagnosed with chronic diseases by Colombian physicians, but then are not able to access the medications or treatments they need. In a case studied by the Constitutional Court in 2019, an undocumented immigrant reported she was diagnosed with lupus, high blood pressure and edema and the Colombian hospital provided her with basic health care and ordered the performance of various laboratory tests, as well as to continue with the treatment prescribed in

²²⁹ Ibid, 45.

²³⁰ (Translated by the author) Natalia Arenas, “For Venezuelans, pregnancy is a crossroads”, *Cero Setenta*, December, 2019. <https://cerosetenta.uniandes.edu.co/para-las-venezolanas-el-embarazo-es-una-encrucijada/>

²³¹ Nancy Berlinger and Rajeev Raghavan, “The Ethics of Advocacy for Un- documented Patients,” *Hastings Center Report* 43, no. 1 (2013): 14-17.

the medical formula. However, the immigrant argued she couldn't access the medicine due to the precarious economic situation she faces.²³² In this case, the Constitutional Court argued that the authorities did not violate the women's right to health care, as the urgent care was provided and the hospital gave her intra hospital medications. The Court established that providing medications outside the hospital was not considered as urgent care in this case.²³³

2.2.3 Advocacy to remove obstacles to the physical and mental health of undocumented immigrants that are due to immigration laws and policies such as detention and family separation

Immigration laws and policies can pose significant obstacles to the physical and mental health of undocumented immigrants. As explained earlier, recent immigration laws and policies have produced various adverse consequences for undocumented immigrants in both countries. These measures not only have included mass deportation and a xenophobic rhetoric, but massive detention and measures that have produced family separation, including children that by March of 2021 are still separated from their parents.²³⁴ This has impacted undocumented immigrants' physical and mental health.²³⁵ This includes health problems such as trauma and depression and physical conditions that are caused or worsened by the lack of attention immigrants receive in

²³² Constitutional Court of Colombia, ruling T-452 of 2019.

²³³ Ibid.

²³⁴ Cynthia Pompa, "Immigrant Kids Keep Dying in CBP Detention Centers, and DHS Won't Take Accountability", *American Civil Liberties Union (ACLU)*, June 24, 2019, <https://www.aclu.org/blog/immigrants-rights/immigrants-rights-and-detention/immigrant-kids-keep-dying-cbp-detention>

²³⁵ Ibid.

detention centers.²³⁶ Physicians and health professionals in the U.S. encountered these healthcare consequences of recent immigration policies such as children and families' separation, massive deportation and massive detention.²³⁷

The wave of immigrants' family separations promoted by the Trump administration has led to psychological and behavioral problems, including suicide attempts and depression.²³⁸ Children have been hospitalized for behavioral health issues that arose during detention, including suicide attempts, signs of trauma and other mental health disorders.²³⁹ By March of 2020, there were over 37,000 people detained by the U.S. Immigration and Customs

²³⁶ Kate Goldman, "No Masks, Disinfectant or Soap. This Is Detention Amid a Pandemic.", *New York Times*, April 2, 2020, <https://www.nytimes.com/2020/04/02/opinion/coronavirus-ice-immigration-detention.html?fbclid=IwAR0RVcsUDDaiX7QUFRfhq0WOEk1rVgMyxdkqpV41Qtz9bP9Ar9Dc7n8bZOo>. Also see: American Immigration Council, the American Immigration Lawyers Association and the Catholic Legal Immigration Network, Letter to Sec. Kirstjen Nielsen Regarding the Detention of Infants, February 2019, https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_urges_immediate_release_of_infants_from_immigration_detention.pdf, Physicians for Human Rights, Letter to Sec. Kirstjen Nielsen Regarding the Detention of Infants (February 2019), https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_urges_immediate_release_of_infants_from_immigration_detention.pdf, "Venezuelan migrants walk back to their country on account of the Coronavirus", *El Espectador*, April 4, 2020, https://www.elespectador.com/noticias/el-mundo/migrantes-venezolanos-caminan-de-regreso-su-pais-por-cuenta-del-coronavirus-articulo-912983?fbclid=IwAR3HYLHtdU5AsFq0hltNLv4-UvQsodfU_tgd1Mi_tHAYxKEUIH2ebZC8_dY

²³⁷ Ibid.

²³⁸ Leila Rafei, "Family Separation, Two Years After MS.L", American Civil Liberties Union *ACLU*, February 26, 2020, <https://www.aclu.org/news/immigrants-rights/family-separation-two-years-after-ms-l/>

²³⁹ Ibid.

Enforcement (ICE) who are at severe risk of contracting COVID-19 and other illnesses, without receiving any health treatment for chronic conditions such as HIV or maternal health attention.²⁴⁰

In February 2019, the American Immigration Council, the American Immigration Lawyers Association and the Catholic Legal Immigration Network warned ICE and the Federal government about children's concerning physical and mental health conditions in the South Texas Family Residential Center (STFRC) detention facility in Dilley, Texas.²⁴¹ Similarly, Physicians for Human Rights have highlighted the critical health situation of immigrants in detention centers, particularly the health risks for infants.²⁴² Also, they have warned about how the "high prevalence of post-traumatic stress disorder, depression, trauma, and mental health issues among parents in detention, often exacerbated by the traumatic experience of detention and lack of adequate mental health care in detention settings, can impact a child's attachment, bonding, and development".²⁴³

²⁴⁰ Joel Rose, "Growing Calls To Close Immigration Courts And Release Detainees As Virus Spreads", *NPR*, March 21, 2020, <https://www.npr.org/2020/03/21/819275605/growing-calls-to-close-immigration-courts-and-release-detainees-as-virus-spreads> Also see: American Immigration Council, American Immigration Lawyers Association, Catholic Legal Immigration Network, Inc., et al., "Administrative complaint filed to Megan Mack, DHS Officer for Civil Rights and Liberties, and John Roth, DHS Inspector Gen. , July 30, 2015, <https://www.aila.org/advo-media/pressreleases/2015/deplorable-medical-treatment-at-fam-detention-ctrs/public-version-of-complaint-to-crcl>

²⁴¹ American Immigration Council, the American Immigration Lawyers Association and the Catholic Legal Immigration Network, Letter to Sec. Kirstjen Nielsen Regarding the Detention of Infants (February 2019). https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_urges_immediate_release_of_infants_from_immigration_detention.pdf

²⁴² Physicians for Human Rights, "Letter to Sec. Kirstjen Nielsen Regarding the Detention of Infants", February 2019, https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_urges_immediate_release_of_infants_from_immigration_detention.pdf

²⁴³ Ibid.

Moreover, there have been reported cases of medical malpractice and deaths of children and adults under the care of ICE facilities.²⁴⁴ On September of 2020, an undocumented immigrant from Jamaica who was living in the Irwin County immigration detention center in rural Georgia claimed that a doctor had performed a non-consented gynecological procedure for an apparent non-necessary reason.²⁴⁵ A nurse from the same detention center argued that she was aware of non-consented hysterectomies performed on immigrants.²⁴⁶ Pauline Binam an immigrant from Cameroon who was in the same detention center reported that after an apparent cyst on her ovary, Doctor Amin explained that he was going to perform a dilation and curettage (D&C) procedure. However, when she woke up, she realized that he had performed a non-consented hysterectomy. This non-consented procedure performed in 2019 has caused her physical and mental health problems.²⁴⁷ According to a *New York Times* 2020 investigation, immigrants in the same detention center have reported cases where the same doctor had performed gynecological procedures, including hysterectomies, without proper informed consent and without a clear explanation of the necessity of the procedure. According to the *New York Times* and five gynecologists, “Dr. Amin seemed to consistently recommend surgical intervention, even when it did not seem medically

²⁴⁴ Cynthia Pompa, “Immigrant Kids Keep Dying in CBP Detention Centers, and DHS Won’t Take Accountability”, American Civil Liberties Union (ACLU), June 24, 2019, <https://www.aclu.org/blog/immigrants-rights/immigrants-rights-and-detention/immigrant-kids-keep-dying-cbp-detention>

²⁴⁵ Caitlin Dickerson, Seth Freed Wessler and Miriam Jordan “Immigrants Say They Were Pressured Into Unneeded Surgeries”, *The New York Times*, September 29 of 2020, <https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html>

²⁴⁶ Ibid.

²⁴⁷ Ibid.

necessary at the time and nonsurgical treatment options were available.”²⁴⁸ This pattern of “excessively aggressive surgical interventions” has been related to monetary benefits that might come from these interventions, as they are well paid to independent doctors by Department of Homeland Security funds.²⁴⁹ Also, women who were interviewed reported problematic practices of informed consent including giving the informed consent form without a proper explanation or translation, in the cases of the non-English speaking immigrants. In other cases, women reported that the doctors explicitly violated consent requirements, performing procedures that they did not want to undergo.²⁵⁰

Even if Venezuelan undocumented immigrants in Colombia have not faced detention for their immigration status, and deportation and family separation are uncommon, they are also facing governmental measures that can highly impact their health. During the 2020 COVID-19 pandemic undocumented immigrants have experienced very difficult circumstances, including lack of job opportunities, food scarcity and extreme poverty as Colombia’s lock down measures closed many informal job opportunities they had before. This situation has pushed immigrants, especially undocumented and vulnerable ones, to go back to Venezuela. Their desperate return has also been impelled by the pressure of not having access to health care in Colombia and the decision of the Colombian government to close the “formal frontier” between Venezuela and Colombia at the

²⁴⁸ Ibid.

²⁴⁹ Ibid.

²⁵⁰ Miranda Bryant, “unwanted hysterectomy allegations ice Georgia immigration”, The Guardian, September 21, 2020, <https://www.theguardian.com/us-news/2020/sep/21/unwanted-hysterectomy-allegations-ice-georgia-immigration>

beginning of March.²⁵¹ This situation is exacerbated by the precarious state of the Venezuelan health system and the climate of violence that Venezuelans face returning by informal and insecure roads. For example, an immigrant explained how he had to walk for 30 days in order to go back to Venezuela as he had nothing to eat in Colombia.²⁵² Also, undocumented immigrants are not being provided with basic preventive care and they are left to sleep in the streets, without public services or proper human distancing measures.²⁵³ An estimated of 90,000 immigrants have returned to Venezuela where they have also faced a climate of rejection and have even been portrayed as a “threat” to public health, “biological weapons” and a “strategy from the right” to destabilize the Venezuelan regime.²⁵⁴ Thus, the Colombian government’s lack of action to protect Venezuelan immigrants from the pandemic and the decision to close the formal frontier between both countries have also had an impact on undocumented immigrants’ physical and mental health.

Overall, current immigration measures in the US and Colombia have clearly had an impact on undocumented immigrants’ physical and mental health, creating an important space and opportunity for physicians’ advocacy. But what actions and measures does physician advocacy include?

²⁵¹ (Translated by the author) Tamara Taraciuk, “Stranded on the Venezuelan border with the threat of Covid-19”, *Human Rights Watch*, July 15, 2020, <https://www.hrw.org/es/news/2020/07/15/varados-en-la-frontera-venezolana-con-la-amenaza-de-covid-19>

²⁵² Ibid.

²⁵³ Ibid.

²⁵⁴ (Translated by the author) Natalia Plazas, “More than 90,000 Venezuelans have returned to Venezuela from Colombia during the pandemic”, *France 24*, July 22, 2020, <https://www.france24.com/es/20200721-venezuela-migrantes-colombia-retorno-coronavirus>

2.3 Advocacy by means of what actions or measures?

For LeeAnne M. Luft advocacy can be defined as “undertaking the necessary action(s) to bring about positive change for the patient or group of patients.”²⁵⁵ Dobson explains that advocacy has two elements: agency and activism. While agency refers to actions directed at specific patients, activism seeks to impact social conditions that have an impact on health, including the health of the community and society.²⁵⁶ Generally, community level advocacy can involve activism when physicians participate in large scale actions that include “system-level activists with the goal of creating lasting change to a system or policy”.²⁵⁷ For Lisa Parker, “In any domain—ethics, medicine, politics—activist activity is intended to disrupt ‘business as usual,’ to cause a rupture that draws attention to systemic flaws particularly injustices.”²⁵⁸ Similarly, for Greg Moorlock activism “does require the taking of action and campaigning, and making a concerted effort to make people pay attention beyond that which is required to meet one’s strictly academic goals.”²⁵⁹

²⁵⁵ LeeAnne M. Luft, “The essential role of physician as advocate: how and why we pass it on”, *Canadian Medical Education Journal*, 8 no 3 (June 2017): e109–e116, e110.

²⁵⁶ Josh Freeman, “Physician advocacy, activism and politics”, *Medicine and Social Justice*, October 13, 2012, <https://pnhp.org/2012/10/15/physician-advocacy-activism-and-politics/>

²⁵⁷ Ibid. Also see: Hubinette MM, Ajjawi R, Dharamsi S, “Family physician preceptors' conceptualizations of health advocacy: implications for medical education”, *Acad Med*. 89 no11 (Nov 2014) :1502-9.

²⁵⁸ Lisa Parker, “Bioethics as activism” in Lisa A. Eckenwiler & Felicia Cohn (eds.), *The Ethics of Bioethics: Mapping the Moral Landscape* (Baltimore: Johns Hopkins University Press, 2007).

²⁵⁹ Greg Moorlock, “Do junior academic bioethicists have an obligation to be activists?”, *Bioethics*. 33 (2019):922–930, 924.

Even if many authors have proposed a distinction between individual and collective advocacy actions, it is important to mention that when a physician advocates for an individual patient it can have an impact on the systemic situation and when a physician advocates for collective causes such as a legal or policy change it will certainly affect individual patients. Along these lines, Nancy Berlinger observes that individual patient advocacy or “walk around” strategies to benefit undocumented immigrants can impact how professionals allocate their time among different patients and populations.²⁶⁰ Specifically, this is reflected in “how they make judgments and participate in resource allocation, directly or indirectly, through their decisions to advocate (or not to advocate) for particular patients.”²⁶¹ Even particular decisions can have a collective positive or negative impact on undocumented immigrants generally.

Advocacy, as I understand it, is a combination of targeted actions for change, which can involve both actions to directly promote the health of individual patients and actions to address laws and policies that affect a group of individuals, and specifically immigrants’ health conditions. I understand activism to be within the scope of advocacy, and when this work refers to advocacy it includes individual and community level actions, understanding individuals are affected by systemic situations.²⁶² Following Earnest, advocacy as I understand it doesn’t require physicians

²⁶⁰ Nancy Berlinger, “Is It Ethical to Bend the Rules for Undocumented and Other Immigrant Patients?”, *AMA Journal of Ethics*, 21, no 1: E100-105.

²⁶¹ Nancy Berlinger and Rajeev Raghavan, “The Ethics of Advocacy for Un- documented Patients,” *Hastings Center Report* 43, no. 1 (2013): 14-17, 15. Also see: Berlinger N. *Are Workarounds Ethical?: Managing Moral Problems in Health Care Systems*. (New York: Oxford University Press; 2016).

²⁶² Hubinette MM, Ajjawi R, Dharamsi S. “Family physician preceptors' conceptualizations of health advocacy: implications for medical education”, *Acad Med*, 89 no 11 (Nov 2014) :1502-9.

to become experts in other fields of knowledge such as public policy or law. Instead, physicians' advocacy is grounded in "their professional experience and work life."²⁶³

The specific actions required for advocacy depend in part on its aim. As this section has explained, physicians' advocacy can involve different aims: removing barriers for undocumented immigrants' access to health care; removing the barriers they face navigating the health system and obtaining high quality care; and removing the threats they face to their physical and mental health due to immigration laws and policies. Examples of physician advocacy that involve these aims include: policy papers, public petitions, lobbying, and participation in policy and legal discussions by commenting and submitting opinions through official channels.²⁶⁴ In many cases, this work can be done through professional societies and by coalition building.²⁶⁵ For example, the American Academy of Pediatrics (AAP) produced a policy brief in which they specifically asked for "health insurance coverage for every child and every individual living in the United States, as lack of coverage for any family member affects the health of the entire family. This advocacy should focus on expanding access to quality health care within a medical home."²⁶⁶ Furthermore, the AAP highlighted the health impacts that policies such as family separation might have on undocumented children, stating that "children whose parents are taken into custody and/or deported have been shown to experience mental and emotional health problems, including sleeping

²⁶³ Mark A Earnest, Shale L. Wong and Steven G. Federico, "Perspective: Physician advocacy: what is it and how do we do it?" *Acad Med*, 85 no 1 (Jan 2010): 63-67.

²⁶⁴ *Ibid.*

²⁶⁵ LeeAnne M. Luft, "The essential role of physician as advocate: how and why we pass it on", *Canadian Medical Education Journal*, 8 no 3 (June 2017): e109–e116.

²⁶⁶ American Academy of Pediatrics, "Policy Statement. Providing Care for Immigrant, Migrant, and Border Children", *PEDIATRICS* 131, no 6, (2013): e2028- e2034.

and eating disturbances, anxiety, depression, poor school performance, and other types of distress.”²⁶⁷ The AAP also invited pediatricians to “use their positions of respect in communities to promote the value of diversity and inclusion and to advocate for children and families of all backgrounds.”²⁶⁸

Similarly, some medical associations in Colombia have advocated for undocumented immigrants’ access to reproductive and obstetric care.²⁶⁹ Specifically, they have provided technical concepts before the Constitutional Court in order to argue that prenatal and obstetric care should be considered crucial for the life of Venezuelan immigrants and should be considered a medical urgency, as lack of access to services related to pregnancy can cause mortality and morbidity.²⁷⁰ The International Federation of Gynecology and Obstetrics (FIGO) and The Colombian Federation of Obstetrics and Gynecology (FECOLSOG) have explicitly referred to the situation of Venezuelan women living in Colombia, stating that they need “(...) access to sexual and reproductive health care services to meet the unmet need for modern contraceptive methods and reduce the number of unwanted or adolescent pregnancies; safe abortion and post-abortion care; protection against sexual exploitation and integrated care to combat sexual and gender violence; maternal health care, prenatal care and deliveries in hospitals supervised by qualified health professionals; neonatal healthcare; programs for the detection and screening of reproductive morbidity and cancer and, of course, attention to the needs of middle-aged women. And, in the

²⁶⁷ Ibid, e2033

²⁶⁸ Ibid.

²⁶⁹ (Translated by the author) Constitutional Court of Colombia, ruling SU-677 of 2017.

²⁷⁰ (Translated by the author) Constitutional Court of Colombia, ruling SU-677 of 2017.

case of refugee women, these services must be provided in the primary care setting on a broader scale.”²⁷¹

Furthermore, promoting individual patients’ empowerment, including health rights education can be another way of advocating for undocumented patients. Altaf Saadi argues that in order to create safe hospitals for immigrants, as a way of rights education hospitals and physicians can “(...) conduct patient awareness campaigns to inform patients that their personal information will not be shared with ICE.”²⁷² In the context of the Emergency Department, Shamsheer Samra and colleagues explain that physicians treating undocumented patients should be able and willing to provide information about the types of immigration relief and the benefits and chances of obtaining legal immigrant status.²⁷³ Even if physicians do not have sufficient knowledge about the immigration legal landscape, they should have basic information to provide and then connect the person with a relevant organization or legal partner. Patient rights education can be facilitated by strengthening connections and collaborations with human rights and advocacy groups and organizations. As Shamsheer Samra and colleagues explain, partnerships with community-based organizations and legal aid groups can help create a safety net for undocumented patients and “establish more robust systems of social screening, referral and case management out of the

²⁷¹ International Federation Gynecology and Obstetrics), “Statement on Health of Refugees and Migrants in Colombia”, June 19, 2019, <https://www.figo.org/es/declaracion-sobre-la-salud-de-las-refugiadas-y-las-inmigrantes-en-colombia>

²⁷² Altaf Saadi, Sameer Ahmed, Mitchell H. Katz, “Making a Case for Sanctuary Hospitals” *JAMA*, 318, No 21(2017): 2079-2080, 2080.

²⁷³ Shamsheer Samra, Breena R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities”, *Western Journal of Emergency Medicine* 20, no. 5 (Sept 2019): 791-798.

Emergency Department to facilitate referrals.”²⁷⁴ In the section of case studies, I will discuss the example of “sanctuary doctoring” from Loyola University where physicians send specific messages to undocumented patients and put them in contact with advocacy groups that can address their immigration needs.

Other examples of advocacy include engaging in public discussions, contributing to media and health reporters and using social media and research in order to publicize the harms and the effects that immigration injustices have for public and individual health. Rachel Fabi argues that engaging in public discussions, publicizing the harms that come to persons who are disadvantaged by them, and criticizing powerful agents who encourage the injustices or at least allow them to happen can be ways of advocating for undocumented immigrants.²⁷⁵ Fabi explains how physicians and bioethicists could advocate against the 2019 rule from the Department of Homeland Security that allows the DNA collection from undocumented immigrants in detention centers. She shows how writing columns that point out the injustices this measure can create and how it was problematic from the bioethical perspective and writing comments during the public comment period were effective means of advocacy.²⁷⁶ Another example is the coverage of the forced sterilization and gynecological procedures on undocumented immigrants in Georgia. In this case, the voices of physicians were heard through media coverage. The *New York Times* interviewed five gynecologists with medical school affiliations who concluded that “Dr. Amin consistently

²⁷⁴ Ibid, 795.

²⁷⁵ Rachel Fabi, “Mandatory collection of DNA of immigrants in US detention centers”, World Bioethics Congress, June 2020.

²⁷⁶ Craig Klugman, “Immigrant DNA Collection: Fighting Crime or Moral Panic”, *The Hasting Center*, October 29, 2019, <https://www.thehastingscenter.org/immigrant-dna-collection-fighting-crime-or-moral-panic/>

overstated the size or risks associated with cysts or masses attached to his patients' reproductive organs."²⁷⁷ Using their expertise to highlight the health abuses against undocumented immigrants in detention centers is a clear way of advocacy.

This section has described the situation of undocumented immigrants in the United States and Colombia and their health condition. I have shown that: there are significant health disparities among undocumented immigrants in both countries; this population suffers from discrimination; and stigma and xenophobia have an impact on immigrants' health and the care they receive. Advocacy was defined and three aims of physician advocacy were identified: removing barriers that prevent undocumented immigrants from accessing the health system; removing barriers and obstacles they face when they are able to access health care and that diminish the quality of care they receive; and preventing the harm that immigration policies can cause to undocumented immigrants' health. Several examples of physician advocacy to achieve these aims were provided. Next section will consider reasons why physicians should advocate for undocumented immigrants' health.

²⁷⁷ Caitlin Dickerson, Seth Freed Wessler and Miriam Jordan, "Immigrants Say They Were Pressured Into Unneeded Surgeries", *The New York Times*, September 29 of 2020, <https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html>

3.0 A defense of physician advocacy

Having explained what it means to advocate for undocumented immigrant's health in the United States and Colombia, I provide three arguments in defense of physician advocacy. First, I argue that when physicians advocate for the health of undocumented immigrants they are pursuing legitimate goals of medicine, under a contemporary reinterpretation that has linked these goals with advocacy against health injustices. Second, I argue that physicians' position in society puts them in a unique position to advocate for the most vulnerable populations. Finally, I consider arguments against physicians' advocacy and provide counterarguments.

3.1 The goals of medicine and physicians' advocacy

Advocacy for the health of undocumented immigrants is consistent with traditional and contemporary interpretations of the goals of medicine. The Hasting Center identifies the following traditional goals of medicine: saving and extending life, promoting and maintaining health, and relieving pain and suffering. However these goals are said to be open to external influence, sources of stress and new demands that require new horizons and interpretations.²⁷⁸ Among these sources of stress, the Hasting Center includes: i) scientific and technological development; ii) the need to balance curative bias; iii) the challenges of the aging population; iv) public and market demands;

²⁷⁸ The Hastings Center, "The Goals of Medicine. Setting New Priorities", *The Hasting Center Report*, Special Supplement (November, 1996): S1-S27.

v) cultural pressures; vi) the medicalization of life; and the vii) the push for human enhancement.²⁷⁹

Considering these pressing demands, it is necessary to question and have an open conversation about traditional goals in order to set “appropriate cotemporary goals for medicine”.²⁸⁰ The Hastings Center endorses the following contemporary reinterpretation of the traditional goals of medicine: i) The prevention of disease and injury, and the promotion and maintenance of health; ii) the relief of pain and suffering caused by maladies; iii) the care and cure of those with a malady, and care of those who cannot be cured; and iv) the avoidance of premature death and the pursuit of a peaceful death.

3.1.1 Preventing disease and promoting health

When physicians are involved in actions to prevent the underlying or root causes of disease and malady, they are not doing anything different than promoting health and preventing disease and bad health outcomes. Even if the promotion of health has traditionally been understood as part of public health rather than medicine, “(...) it might be possible in the years ahead to bring into closer working relationship two critical fields of health care- medicine and public health-that too long have worked separately, often in competition with each other.”²⁸¹ The prevention of disease and suffering, and the maintenance of health can involve measures that are outside the “medical arena.”²⁸² In addition, prevention measures might involve other people and won’t be limited to

²⁷⁹ Ibid, s3-s6.

²⁸⁰ Ibid.

²⁸¹ Ibid, s10.

²⁸² Ibid.

the individual patient. Bioethicists have maintained that physicians need to transcend “ad hoc solutions” to provide health for undocumented immigrants and should focus on advocacy strategies that can address institutional policies and organizational ethics.²⁸³ As Jeanne Merkle Sorrell explains, physicians’ advocacy for undocumented patients might involve different stakeholders such as “healthcare professionals, administrators, long-term care facilities, government agencies, and local, state, and national governments.”²⁸⁴ Actions such as participating in media discussions, educational activities and advocacy for causes that are interconnected with the health of people are ways of preventing diseases and promoting health. Thus, medical advocacy is connected with the ultimate end of promoting health for all people, without distinction.

3.1.2 Relieving pain and suffering

Pain cannot be understood as merely physical distress, which historically has been part of physicians’ goal. The Hasting Center refers to the importance of reinforcing the relief of “psychological burden or oppression” which can include “(...) the suffering of mental illness, or simply the ordinary fears of life, [and] does not necessarily include physical pain.”²⁸⁵ As stated in the previous section, undocumented immigrants are especially vulnerable to psychological

²⁸³ Nancy Berlinger and Rajeev Raghavan, “The Ethics of Advocacy for Un- documented Patients,” *Hastings Center Report* 43, no. 1 (2013): 14-17.

²⁸⁴ Sorrell, J.M., "Ethics of Advocacy for Undocumented Patients" *OJIN* 22, no. 3, (July 2017)

²⁸⁵ The Hastings Center, “The Goals of Medicine. Setting New Priorities”, *The Hasting Center Report*, Special Supplement (November, 1996): S1-S27, S11.

suffering due to their difficult contexts and policies such as family separation.²⁸⁶ In this case, even if suffering might not be caused by organic causes, the social circumstances play a clear role in immigrants' health conditions. Thus, when physicians advocate for undocumented immigrants to prevent suffering and mental distress, they are promoting a core goal of medicine.

3.1.3 Caring and curing

Even if traditionally physicians have been concerned with diagnosing, treating and, in some cases, curing health conditions, caring has sometimes been forgotten.²⁸⁷ In the medical context, caring can be defined as “(...) the manifestation of concern, empathy, and a willingness to talk with patients. It is also a capacity to talk and listen in a way that is cognizant of those supportive social and welfare services needed to help people and their families cope with the wide range of non- medical problems that can and usually will accompany their illness. Of necessity, good caring demands technical excellence as a crucial ingredient.”²⁸⁸

Care has also been understood as a fundamental aspect of developing and maintaining trust between doctors and patients. For Laura Specker Sullivan professional competence, care and comprehension are key factors to build trust in the medical relationship, which in many cases is

²⁸⁶ Leila Rafei, “Family Separation, Two Years After MS.L”, American Civil Liberties Union *ACLU*, February 26, 2020, <https://www.aclu.org/news/immigrants-rights/family-separation-two-years-after-ms-l/>

²⁸⁷ The Hastings Center, “The Goals of Medicine. Setting New Priorities”, *The Hasting Center Report*, Special Supplement (November, 1996): S1-S27.

²⁸⁸ *Ibid*, S12.

absent.²⁸⁹ Even if trust is a fundamental part of the physician-patient relationship, mistrust has become common among communities that have been traditionally disregarded by the profession and the health system, especially among African Americans.²⁹⁰ Stefan Timmermans and Hyeyoung Oh maintain that even if trust is presupposed in the medical relationship and historically people have reported high levels of trust in physicians, this trust has been declining since the 1970s influenced by consumerism around health, the rise of health movements and patients' advocacy around autonomy and humane choices, and an increase of accountability and malpractice litigation.²⁹¹ Specker argues that in order to rebuild trust in difficult contexts, physicians should care and comprehend the situation of patients and the reasons why, in many cases, they don't trust the institution of medicine. They must do this in a way in which patients feel the physician is trustworthy and understands their interests, vulnerability and dependence on his or her knowledge.²⁹² As indicated before, undocumented immigrants mistrust doctors and medical settings because they are afraid their immigration status will be revealed or that immigration authorities will have access to their information. Thus, caring for undocumented patients also means being able to comprehend that the mistrust of undocumented patients can manifest "as a refusal to make a decision, which providers may interpret as noncompliance."²⁹³ Therefore, it is

²⁸⁹ Laura Specker Sullivan, "Trust, Risk, and Race in American Medicine," *Hastings Center Report* 50, no. 1 (2020): 18-26.

²⁹⁰ *Ibid.*

²⁹¹ Stefan Timmermans and Hyeyoung Oh, "The Continued Social Transformation of the Medical Profession", *Journal of Health and Social Behavior*, 51 (2010): S94-S106.

²⁹² Laura Specker Sullivan, "Trust, Risk, and Race in American Medicine," *Hastings Center Report* 50, no. 1 (2020): 18-26, 21.

²⁹³ *Ibid.*, 22.

important to critically analyze situations where undocumented patients won't follow medical instructions and address them in an empathetic way, understanding their specific contexts and mistrust.

Care and comprehension can be related to what has been referred to as "individual patient advocacy" that can go beyond the routine practice of medicine and includes resourceful ways to address and overcome the difficulties patients face. Individual patient advocacy can require to go outside the "medical arena" and can involve rights empowering, which in some cases can be done directly by the physician through conversation or written material. Also, physicians can actively connect patients with human rights networks and advocacy organizations that can better address some of the legal worries and the social barriers they encounter. This requires an active job of mapping the relevant organizations and available resources in a specific area. This work can sometimes require physicians to go beyond the patient specific health need and take more time to inquire about patients' migration history in order to identify other social needs that might be impacting their overall situation.

Moreover, when physicians advocate for the elimination of stigma and xenophobia in the health setting they are contributing to the goal of caring. This can be done with simple acts such as stating that immigrants' legal status won't be revealed to immigration authorities and won't determine the quality of attention they need. This contributes to the construction of safe environments for the undocumented patients and promotes an inclusive environment among the medical community. Another way to promote the elimination of stigma can be confronting personal biases and pre-conceptions about undocumented immigrants. Physicians can do this as an individual or collective exercise that requires them to learn more about immigrants' realities, the difficult contexts that they have been facing and the ways this can impact their health. Then,

advocacy can be an effective way of caring which can not only improve their relationship with medical institutions, but also eliminate or reduce the climate of mistrust that is common among this population.

3.1.4 Pursuing a peaceful death

Finally, the core goal of pursuing a peaceful death can also be promoted by advocacy for undocumented immigrants. In the context of terminal diseases and end of life conversations, it is common to find ethical tensions in relation to caring for undocumented patients. According to Mark Kuczewski, "End-of-life care [for undocumented patients] poses challenges at both ends of the ethical spectrum"²⁹⁴. On the one hand, he explains that having an undocumented and uninsured patient with long-term medical needs might bring complicated scenarios where physicians might be trying to avoid the economic burden and will advocate for solutions such as patient repatriation to the birth country or pressures to transition to comfort care. Undocumented patients' repatriation has become a common and controversial practice, especially when it is done without their clear consent and in cases where sending patients back won't guarantee their best interest or continuity of care.²⁹⁵ This is the case of immigrants whose birth country lacks proper medical facilities or professionals, such as the case of Venezuela, Honduras and El Salvador. On the other hand, Kuczewski points out that physicians might also want to avoid transitioning the patient to comfort

²⁹⁴ Mark Kuczewski, "Can Medical Repatriation Be Ethical? Establishing Best Practices", *The American Journal of Bioethics*, 12 no 9 (Aug, 2012): 1–5, 1.

²⁹⁵ Ibid. Also see: "Undocumented patients face unique ethical concerns with end-of-life care", *Relias Media*, December 1, 2014, <http://www.ahcmedia.com/articles/111455-undocumented-patients-face-unique-ethical-concerns-with-end-of-life-care>

care, because they “(...) fear that they might be using death to relieve financial dilemmas.”²⁹⁶ This is also problematic, as in many cases resources ended up being overused.²⁹⁷

Ideally, dignified end-of-life care should be part of the routine ethical practice of medicine and non-consented repatriation should be understood as a practice that is contrary to the ethical norms of medicine. However, the current lack of legal health protection of undocumented immigrants leads to a scenario where this population struggle to get this type of care and is subjected to non-ethical end-of-life practices. Thus, physician’s advocacy is crucial to promote this medical goal in this population.

In order to advocate, physicians can promote actions to make visible the difficult reality of medical repatriation, by sharing stories and raising awareness with the media and among medical and non-medical organizations. Also, physicians can actively promote and participate in the construction of internal institutional policies and protocols that highlight the importance of palliative care for uninsured undocumented immigrants and require transparent conversations about the end-of-life of patients that can be considered a financial “burden” for the institution or the system. These protocols should include clear processes and the need to involve different institutional stakeholders, including bioethicists and ethical consultants. This advocacy work can also be done in a public policy state or federal level. Moreover, physicians can advocate by refusing to participate in repatriation practices that have not been consented by the patient or do not promote his/her wellbeing. Saying no and standing up against unethical practices can be an effective way of creating collective awareness among peers. These advocacy actions are in the scope of the goal

²⁹⁶ Ibid, 4.

²⁹⁷ Ibid.

of pursuing a peaceful death and are an effective way in which physicians can help minimize immigrants' pain and suffering at the end of life.

3.1.5 Medical associations and the reinterpretation of medical goals

The reinterpretation of medicine's core goals in the light of the contemporary social challenges has recently led medical associations to progressively include advocacy as part of physicians' professional responsibilities and integral role. The American Board of Internal Medicine added commitment to public advocacy as part of medical professionalism.²⁹⁸ Likewise, the American Medical Association (AMA) Declaration of Professional Responsibility has added advocacy as one of physicians' responsibilities maintaining that physicians should "advocate for social, economic, educational, and political changes that ameliorate suffering and contribute to human well-being."²⁹⁹ Similarly, the Canadian Medical Association, the College of Family Physicians of Canada (CFPC), and the Surgeons of Canada (RCPSC) have addressed advocacy as part of professional responsibilities.³⁰⁰ According to both institutions, physicians should be

²⁹⁸ ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine., "Medical professionalism in the new millennium: A physician charter", *Ann Intern Med.* 136 (2002): 243–246.

²⁹⁹ American Medical Association, "Declaration of Professional Responsibility", December 4, 2001, <https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility#:~:text=We%2C%20the%20members%20of%20the,and%20compassion%20and%20without%20prejudice.>

³⁰⁰ LeeAnne M. Luft, "The essential role of physician as advocate: how and why we pass it on", *Canadian Medical Education Journal*, 8 no 3 (June 2017): e109–e116.

committed to advocacy as “advocating within and beyond the clinical environment” and for the systemic-level needs of communities is related with individual patient’s health.³⁰¹

Specifically, the American Medical Association -AMA- has addressed advocacy by physicians to promote the health of undocumented immigrants. According to Rachel F. Harbut, the AMA has opposed the criminalization of medical care that is provided to immigrants; has acknowledged the health challenges undocumented and unaccompanied immigrant minors face; and has encouraged the revision and improvement of the health care that is provided to immigrants in detention centers”³⁰². Thus, according to the AMA, advocacy is among the legitimate goals and roles of physicians. As another example of advocacy endorsed by professional organizations, the American Academy of Pediatricians has invited their members to advocate for the health of undocumented children. They state that “Pediatricians and the American Academy of Pediatrics should advocate for health insurance coverage for every child and every individual living in the

³⁰¹ Ibid, e110.

³⁰² Rachel F. Harbut, “AMA Policies and Code of Medical Ethics’ Opinions Related to Health Care for Patients Who Are Immigrants, Refugees, or Asylees”, *AMA Journal of Ethics*, 21, no 1 (January 2019): E73-77. Citing: American Medical Association. Opposition to criminalization of medical care provided to undocumented immigrant patients H-440.876, <https://policysearch.ama-assn.org/policyfinder/detail/immigrants?uri=%2FAMADoc%2FHOD.xml-0-3892.xml>. American Medical Association. Medical needs of unaccompanied, undocumented immigrant children D-65.992. <https://policysearch.ama-assn.org/policyfinder/detail/immigrants?uri=%2FAMADoc%2Fdirectives.xml-0-1971.xml>. American Medical Association. Federation payment for emergency services for undocumented immigrants H-160.917, <https://policysearch.ama-assn.org/policyfinder/detail/immigrants?uri=%2FAMADoc%2FHOD.xml-0-732.xml>. Modified American Medical Association. Improving medical care in immigrant detention centers D-350.983. <https://policysearch.ama-assn.org/policyfinder/detail/immigrants?uri=%2FAMADoc%2Fdirectives.xml-D-350.983.xml>.

United States, as lack of coverage for any family member affects the health of the entire family. This advocacy should focus on expanding access to quality health care within a medical home (...)"³⁰³.

Even if Colombian medical associations have not explicitly addressed advocacy as part of physicians' responsibilities, as stated before, associations such as the Colombian Federation of Obstetrics and Gynecology (FECOLSOG) has actively participated in advocacy for undocumented immigrants' health.

3.1.6 Reinterpretation of the medical goals and justice

The reinterpretation of the medical goals and professional duties under contemporary circumstances has also suggested the need to address health injustices. This is related with pressing social factors such as the need to address the root of diseases and the need to balance the curative bias with a bigger emphasis on prevention of diseases and persisting health conditions. Also, as it was expressed before, the contemporary sense of caring has pushed physicians to transcend the individual patient perspective and carry out actions in order to address a wide range of social problems that might be understood as out of the "medical arena", but are completely connected with patients' medical situation. In this line, LeeAnne Luft claims that physicians have a duty to

³⁰³American Academy of Pediatrics, "Policy Statement. Providing Care for Immigrant, Migrant, and Border Children", *PEDIATRICS*, 131, no 6, (2013): e2028- e2034, p.e2032.

“(…) work towards eliminating societal causes of health inequity on a population level.”³⁰⁴ Luft also considers advocacy as the way in which physicians can address the injustices in healthcare.³⁰⁵

Moreover, physicians should be committed to the principle of justice, and they can display that commitment by advocating for health justice for undocumented immigrants. Justice has been understood as a fundamental principle for clinical and research ethics. Madison Powers argues that bioethics has traditionally used the principle of justice to call attention to health inequalities, unequal access to medical research and its development, unequal access to health care, and health prioritization in contexts of scarce resources.³⁰⁶ However, Joseph Millum and Ezekiel J. Emanuel argue that concerns around international and global aspects of justice are a more recent bioethical debate. Thus, for them, a more global approach to justice in health should involve questions of distributive justice and the division of benefits and burdens in social systems.³⁰⁷ Then, it is possible to argue that: i) Advocacy is a strategic way in which physicians can address and act upon the existence of a structural health injustice against undocumented immigrants; and ii) advocacy can be a way in which physicians can respond to the demand of restorative justice in relation with past medical abuses perpetuated over immigrants.

³⁰⁴LeeAnne M. Luft, “The essential role of physician as advocate: how and why we pass it on”, *Canadian Medical Education Journal*, 8 no 3 (June 2017): e109–e116, e110.

³⁰⁵ Ibid.

³⁰⁶ Madison Powers, et al. *Social Justice: The Moral Foundations of Public Health and Health Policy* (Oxford: University Press, 2008), 3.

³⁰⁷ Joseph Millum and Ezekiel J. Emanuel, *Global Justice and Bioethics* (Oxford: Oxford Scholarship:2015)

3.1.6.1 Advocacy to address the structural health injustice in relation to undocumented immigrants

As it has been expressed in this thesis, undocumented immigrants face several barriers to health care access. This can manifest in worse health outcomes and the persistence of a structural health injustice. The concept of *health justice* can be understood as a development of the principle of equality that maintains that “all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity.”³⁰⁸ Emily Benfer explains there is a direct connection between health equity and a larger understanding of justice. This requires us to understand how social determinants of health, race and poverty affect the health of people. Moreover, she suggests four aspects that are required in order to achieve health justice: “(1) developing primary prevention policies; (2) prohibiting, amending, or repealing laws adversely affecting health; (3) ending discrimination and racial bias; and (4) listening to, engaging, and developing affected communities.”³⁰⁹

A *structural injustice* can be found when there is an institutional, accepted practice that creates an unequal situation that tends to be morally accepted.³¹⁰ In this case, the unequal situation consists in undocumented immigrants who are poorer and more vulnerable than other populations, having a bad quality of life, higher mortality rates and lower life expectancy, as they cannot legally

³⁰⁸ Emily A. Benfer, “Health justice: A framework (and call to action) for the elimination of health inequality and social injustice”, *Am. U.L Rev.* 65 no 275 (2015): 275-351, 278.

³⁰⁹ *Ibid*, 338.

³¹⁰ Iris Marion Young, *Responsibility for Justice*, (Oxford: Oxford University Press, 2013), 122.

access health care and don't have enough money to pay for it.³¹¹ As it was explained in the previous chapter, the unequal health situation of undocumented immigrants can be explained by institutional practices, reflected in different laws, regulations, policies and health and administrative practices that have been socially accepted and have perpetuated the status quo. Consequently, from a health justice framework, all people, including those who are undocumented, should have similar opportunities and the fair formation of capabilities to accomplish their full health potential, and in this way, health disparities will become less evident among populations and communities.³¹²

Considering that undocumented immigrants in the United States and Colombia face a structural health injustice, advocacy is an appropriate way to address this situation. Mark Kuczewski argues that advocating for the health of undocumented immigrants is a way to pursue justice, as not being able to provide health care for them creates unjustifiable differences among groups of people, which can be compared to Jim Crow laws and racial segregation.³¹³ Physicians are involved in the improvement of people's health in their everyday practice, but this won't necessarily help to tackle more systemic health injustices, as in many cases, the patients that have been left out from the opportunities of health care don't ever make it to health centers. Also, even when physicians take care of individual undocumented patients, this might not be enough to change their status quo and prevent a "revolving door" where patients keep coming back to the

³¹¹ Emily A. Benfer, "Health justice: A framework (and call to action) for the elimination of health inequality and social injustice", *Am. U.L. Rev.* 65 no 275 (2015): 275-351, 279. Citing Margaret Whitehead, *The Concepts and Principles of Equity and Health*, 6 *Health Promotion Int'l* 217, 218 (1991).

³¹² *Ibid.*

³¹³ Mark Kuczewski, "The Really New Jim Crow: Why Bioethicists Must Ally With Undocumented Immigrants", *The American Journal of Bioethics*, 16 no 4 (April, 2016): 21-24.

health care system for similar and even worse health problems, as the situation that might be causing them is persisting and there are not appropriate ways of treating the problem.³¹⁴ Hence, advocacy constitutes an effective way in which physicians can reach the most vulnerable people in society that have been excluded from health care and can also contribute to challenge the root causes of diseases and health needs.

3.1.6.2 Restorative justice in response to the role of medicine in the stigmatization of immigrants

Apart from the need to address the structural health injustice that undocumented immigrants face, physicians should also be committed to restorative justice. Going back in history, physicians, the medical establishment, and medical discourse played an important role in the stigmatization and segregation of immigrants as disease carriers. According to Sofya Aptekar, the US Public Health Service “was instrumental in strengthening the association between immigration and danger, disease, and infection, which persists today.”³¹⁵ This process of stigmatization was constructed using medical arguments to strengthen racial differences, portray immigrants as a burden, segregate them and even deport them.

During the European immigration wave to the United States between 1840 and 1860 physicians were responsible for examining incoming immigrants and were the ones to ensure that

³¹⁴ Nancy Berlinger and Rajeev Raghavan, “The Ethics of Advocacy for Un- documented Patients,” *Hastings Center Report* 43, no. 1 (2013): 14-17,16.

³¹⁵ Sofya Aptekar, “Doctors as migration brokers in the mandatory medical screenings of immigrants to the United States”, *Journal of Ethnic and Migration Studies*, (June, 2019): 1-19,2.

people with infectious diseases, poor health, or impairments did not enter the country.³¹⁶ The link between medicine, racism and anti-immigration discourse was strengthened in the context of the rise of immigration through the 1880's and 1940's. This was evident in the medical screenings at Ellis Island where physicians measured and determined immigrants' physical and mental fitness for admission. As Alan Kraut mentions, the screening process was shaped by medical advances and new methods for diagnosing diseases such as tuberculosis.³¹⁷ Moreover, physicians created scales and methods to measure mental capacity as means to avoid admitting people with "mental deficiency and insanity" or those who were likely to become public charges.³¹⁸

Medical discourse around immigration changed and was modified as immigrants from other countries became more common in the United States. Natalia Molina examines the case of California and shows how physicians and public health officers developed a discourse in which Asian and Mexican immigrants were portrayed as disease carriers and biologically inferior.³¹⁹ This was related to the 1916 typhus epidemic, the 1924 plague and TB propagation in neighborhoods with a high density of immigrants who typically lived in bad housing conditions. Also, higher infant mortality rates among the immigrant community were used to perpetuate the idea of Mexicans as "genetically flawed".³²⁰ This discourse worsened during the first decades of the twentieth century with the rise of the economic crisis and the eugenic movement. During 1914 the

³¹⁶ Alan M. Kraut, "Bodies from Abroad: Immigration, Health, and Disease", in Reed Ueda (editor), *A companion to American immigration* (Malden: Blackwell Publishing, 2006)

³¹⁷ Ibid, 114.

³¹⁸ Ibid.

³¹⁹ Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939*, (Berkeley: University of California Press, 2006).

³²⁰ Ibid, 101.

United States Public Health Service (USPHS) was connected with the eugenic movement “(...) working with eugenics organizations and producing reports that supported eugenics drives to restrict immigration.”³²¹ Physicians and public health experts used their “scientific objectivity” to defend the idea of hygiene and cleanness as “standards for “Americanness.””³²² According to Molina, “Public health officials, policy makers, and ordinary citizens increasingly relied on medical reasons as the basis for their objections to immigrant populations. Faced with budget cuts and a volatile political atmosphere, Los Angeles public health officials reversed their assimilation policies during the Depression and argued that Mexicans’ biological inferiority precluded any possibility of rehabilitation.”³²³ The medical profession was perceived as the gate keeper of the country, as physicians were responsible for determining who could be considered part of the nation, according to medical standards.³²⁴ Kraut argues that physicians were understood as responsible to “guard the public’s health” and prevent the propagation of potential infections that could affect the country’s productivity and progress.³²⁵

Contrary to what happened in the United States, the medical discourse was used to promote European immigration during the eugenic period in Colombia in order to “whiten” and “improve”

³²¹ Jessica Ordaz, “Migrant detention centers have a long history of medical neglect and abuse”, The Washington Post, September 18, 2020, <https://www.washingtonpost.com/outlook/2020/09/18/migrant-detention-centers-have-long-history-medical-neglect-abuse/>

³²² Natalia Molina, *Fit to Be Citizens: Public Health and Race in Los Angeles, 1879-1939*, (University of California Press, Berkeley: 2006), 14.

³²³ Ibid, 101.

³²⁴ Ibid.

³²⁵ Alan M. Kraut, “Bodies from Abroad: Immigration, Health, and Disease”, in Reed Ueda (editor), *A companion to American immigration* (Malden: Blackwell Publishing, 2006), 115.

the race.³²⁶ Colombian eugenicists linked the existence of social and economic problems with the racial composition of the country, which is predominantly racially mixed and has afro descendant and indigenous communities.³²⁷ Miguel Jiménez López, a Colombian physician and politician, promoted the idea of “racial degeneration” which was understood as a biological problem of the Colombian racial composition, linked to geographic circumstances. Doctor Jimenez Lopez argue that this racial problem could only be resolved by massive European white immigration.³²⁸ Following this deterministic idea of the Colombian racial inferiority, the government enacted legislation that promoted the immigration of Europeans.³²⁹ The Act 114 of 1922 provided “incentives for immigrants whose personal and racial conditions would contribute to the country by creating economic and intellectual development, improving its ethnic, physical and moral conditions, and introducing science and arts, civilization and progress”.³³⁰ Then, European immigrants would receive benefits for entering Colombia, including free housing and hectares of bald lands.³³¹ Contrary to this, Colombian doctors and politicians considered immigration from

³²⁶ Natalia Acevedo, “The medical discourse and the sterilization of people with disabilities in the United States, Canada and Colombia: From eugenics to the present” (LLM dissertation, McGill University, 2015), 87-89, citing Carlos Ernesto Noguera, *Medicina y Política. Discurso médico y prácticas higiénicas durante la primera mitad del siglo XX en Colombia* (Medellin: Fondo Editorial Universidad EAFIT, 2003).

³²⁷ Ibid.

³²⁸ Abel Fernando Martínez, “Trópico y raza. Miguel Jiménez López y la inmigración japonesa en Colombia, 1920-1929”, *Historia y Sociedad*, 32 (Jan-2017): 103-138.

³²⁹ Jaime Carrizosa Moog, “Eugenesia y discriminación en Colombia: el papel de la medicina y la psiquiatría en la política inmigratoria a principios del siglo XX”, *rev colomb psiquiatr* 43 no 1 (2014): 58-63, 62.

³³⁰ Congress of Colombia, *Act 114 about Immigration and agricultural colonies*, 1922, art 1.

³³¹ Ibid, art 12.

Africa, China, Japan or India will harm the country as “(...) The most deficient bodily and physiognomic traits in our population, far from being perfected, would suffer a complete regression when mixed with characteristic specimens of the Mongolian strain.”³³² Following medical theories, the Colombian government incentivized European immigration and considered other type of migration as a “threat” to the already problematic racial composition of the country.³³³

Then, the medical profession and its discourse around immigrants have been responsible for several harms to this population. First, medical arguments have been used and reproduced by politicians and citizens to perpetuate negative ideas about “certain immigrants” that persist until today: “Even today, stereotypes of the overly fertile Mexican woman, the unclean Mexican man, the wily Asian vendor, and the germ-spreading Chinese launderer persist.”³³⁴ These stereotypes have been used to promote discriminatory measures against Mexicans, Asians and immigrants in general. Jessica Ordaz argues that negative stereotypes about immigrants have led to violent actions such as forced sterilizations on Latina women in Los Angeles during the 1960’s and 1970’s.³³⁵ Ordaz connects these historic negative stereotypes about immigrants as disease carriers with the current immigration order, detention measures and bad health conditions and abuses in

³³² Miguel Jiménez Lopez, “Primera conferencia”, in Luis López de Mesa et al. (editor), *Los problemas de la raza en Colombia*, (Bogota: El Espectador, 1920), 75.

³³³ Tanya Hernandez, *Racial subordination in Latin America. The Role of the State, Customary Law and the New Civil Rights Response* (New York: Cambridge University Press, 2013), 46.

³³⁴ Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939*, (Berkeley: University of California Press, 2006), 123.

³³⁵ Jessica Ordaz, “Migrant detention centers have a long history of medical neglect and abuse”, *The Washington Post*, September 18, 2020, <https://www.washingtonpost.com/outlook/2020/09/18/migrant-detention-centers-have-long-history-medical-neglect-abuse/>.

detention centers.³³⁶ Thus, the medicalization of immigrants' identities and the promotion of bad and good stereotypes around immigrants have perpetuated unjust social conditions.

Second, medical arguments against immigrants are connected to complex deterministic and race-based explanations that have historically perpetuated social inequality among racial minorities. The undesirability of immigrants was connected with ideas about their biological inferiority and their tendency towards disease. In the 1920's the California's Bureau of Tuberculosis stated that "(...) Mexicans were inherently less able-bodied and thus more prone to be infected by and be spreaders of tuberculosis (...)"³³⁷ Medical experts argued that Mexicans and other immigrants did not have rehabilitation possibilities as they were unfit and should not be allowed to be in America.³³⁸ In the context of Colombia and other Latin American Countries, stereotypes about white and non-white immigration contributed to a process of "(...) both diminishing blackness and creating a new race diluted of blackness."³³⁹ These type of ideas helped to shape and reinforce racial hierarchies where "some immigrants" were considered as the racial other and the racial "threat" or "opportunity" to improve the race, which determined social orders, perceptions and opportunities in different communities.³⁴⁰ Even if Darwinist theories that supported eugenic and deterministic measures have been scientifically challenged and are now considered "bad science", their impact has perpetuated racism and xenophobia towards immigrants

³³⁶ Ibid.

³³⁷ Natalia Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939*, (Berkeley : University of California Press, 2006), 104.

³³⁸ Ibid, 115.

³³⁹ Ibid at 20.

³⁴⁰ Ibid. Also see: Tanya Hernandez, *Racial subordination in Latin America. The Role of the State, Customary Law and the New Civil Rights Response* (New York: Cambridge University Press, 2013).

who are understood as racially different. This is still present in society and reflected in their persisting social inequalities. The relationship between immigration, health improvement and disease has been an integral part of immigration policies and measures. Not long ago, the United States Surgeon General, Dr. Antonia C. Novello stated, “Viruses and bacteria don’t ask for a green card.”³⁴¹ The social determinants that once placed the burden of disease on immigrants are still affecting immigrant communities in different nations.

Following the negative consequences of the way the medical discourse portrayed immigrants in the past, it is necessary to question how this is connected with justice and physicians’ ethical calling to advocate for undocumented immigrants’ health. To do this, it is necessary to use the concept of restorative justice, which has been understood as “(....) a participatory ‘process whereby all people with a stake in a particular offence [victims, offenders and their ‘communities of care’] come together to resolve collectively how to deal with the aftermath of the offence and its implications for the future”.³⁴² This process has been guided by values such as victim healing, offender accountability, individual empowerment, reconciliation, reparation of the harm, community-orientation, informality, consensual decision-making and inclusiveness.³⁴³ In this case, even if it is not precedent to identify a particular offence or a singular victim and offender, the concept of restorative justice is useful to identify the need of a reparation and the circumstances in which this process should be made. Thus, the restorative justice framework understands

³⁴¹ Alan M. Kraut, “Bodies from Abroad: Immigration, Health, and Disease”, in Reed Ueda (editor), *A companion to American immigration* (Malden: Blackwell Publishing, 2006), 106, citing *Washington Post*, April 24, 1993.

³⁴² Margarita Zernova, *Restorative Justice: Ideals and Realities* (London: Taylor & Francis Group, 2007), 2, citing Marschal, 1998.

³⁴³ Ibid.

reparation as the main goal, which requires an accountability process and the restoration of the social relationship that has been harmed.³⁴⁴ Also, it requires the participation of different parts, including the society and the community that has been harmed by a past injustice.

Consequently, it can be argued that the medical profession should restore the relationship they have had with immigrants and try to repair the harm that this profession has caused many of them. To do this, it is necessary to think about the ways to repair the social, psychological and relational harm they have suffered. Margarita Zernoba states that reparation of these type of harms might involve doing work for people who have been harmed and the strengthening of “offenders” competencies and restoration of the social bond.³⁴⁵ In this case, the medical professions can be understood as “the offender”, as the medical theories and their enforcement by different physicians in different generations have caused the stigmatization and discrimination of the immigrant population. Then, it is first necessary to recognize the past and understand the complicity of the medical profession and the perpetuation of injustices towards immigrants. As Iris Marion Young states “We are responsible in the present for how we narrate the past. How individuals and groups in the society decide to tell the story of past injustice and its connection to or break with the present says much about how members of the society relate to one another now and whether and how they can fashion a more just future.”³⁴⁶ Besides, participating in advocacy can be a way in which physicians recognize the damage the profession has created and an effective way in which they

³⁴⁴ Ibid. p. 41-44.

³⁴⁵ Ibid.

³⁴⁶ Iris Marion Young and Martha Nussbaum, *Responsibility for Justice* (Oxford: Oxford University Press, 2011), p. 210.

can contribute to repair the damage and restore the trust of the community. This might require that physicians develop new competencies and recognize the history of the profession and past harms. Advocating for undocumented immigrants' health is also a way in which physicians can promote the empowerment of the community and of individuals, transcending their individual scope, and promoting a change in the way the profession has allied with this specific community.

Finally, understanding physician's advocacy work as a way of reparation might address some of the criticism that the concept of restorative justice has received. Authors like Pavlich have argued that restorative justice promotes the harmony and stability of the established social order and is not concerned with promoting changes of unjust relationships and power relationships.³⁴⁷ However, by promoting advocacy work as a way of compensating for harms, physicians are also addressing and challenging existing and structural inequalities and injustices. Advocacy is not only an effective way of compensating for past harms. It also is a means to highlight and promote change in the status quo and the ways in which the health system addresses the health needs of undocumented immigrants.

It is clear that advocacy is connected to the traditional core values of medicine and their contemporary reinterpretation in a context of demanding circumstances. Also, that the past and continuing health injustices that undocumented immigrants face have pushed physicians to promote advocacy as part of physicians' aims. Even if advocacy is outside a narrow "medical" or "clinical" arena, it is not incompatible with the goals of medicine.

³⁴⁷ Margarita Zernova, *Restorative Justice: Ideals and Realities* (London: Taylor & Francis Group, 2007), 46, Citing Pavlich, g. (1996a) *Justice Fragmented: Mediating Community Disputes under Postmodern Conditions* (London: Routledge). Pavlich, G. (1996b) 'The Power of Community Mediation: Government and Formation of Self', *Law and Society Review*, 30, 101-127.

3.2 Physician´s privileged social status and knowledge

Physicians are in a unique position to advocate, as they can be closer to decision makers and their perspectives and opinions are better heard by decision makers. This unique position can have two main explanations and manifestations including: i) Physicians´ privileged status, social perception and prestige, which is linked to their technical expertise and influence in public opinion; and ii) their privileged access to information about the health of undocumented immigrants.

3.2.1 Physicians´ privileged social status, prestige and social perception

Traditionally, the medical profession has had social status. From the Roman Empire, physicians as a “professional collective” have been considered part of a privileged occupation that was able to cure and save lives in the Roman imperial army.³⁴⁸ Physicians were acknowledged by the Roman State, enjoyed privileges and were in contact with civic aristocracies.³⁴⁹ These privileges were also explained by the role they provided before judicial courts where they were consulted for their expert opinion and forensic analysis in order to resolve legal cases involving violence and inheritance rights. This participation in legal cases increased the power and influence of the profession.³⁵⁰ Derek Portzwood and Alan Fielding discuss the history of physicians´ status and trace it back to the origins of the medical profession in England and the Royal College of

³⁴⁸ Ido Israelowich, “Physicians as Figures of Authority in the Roman Courts”, *Historia: Zeitschrift für Alte Geschichte*, Bd. 63, H. 4 (2014): 445-462,455.

³⁴⁹ Ibid.

³⁵⁰ Ibid, 458.

Surgeons, which was one of the first institutions where doctors organized.³⁵¹ Even if the medical profession evolved and changed with the industrialization of nations and the consolidation of states, physicians kept their “high status of all its members on the basis of its gentlemanly antecedents and its current specialist knowledge”³⁵².

This historical privilege can be explained by and has caused physicians to enjoy wealth, power and status.³⁵³ Physicians have traditionally had socio economic status and wealth, as their profession has traditionally been well remunerated.³⁵⁴ Even if these privileges have changed over time, the medical profession has used different mechanisms to keep their power by using professional organizations and ideology.³⁵⁵ This power and status is not only explained by wealth. In most cases, the profession has control over the patients they choose and the treatments they recommend, and the power over their own affairs and self-regulation.³⁵⁶ Moreover, this status is reflected in physicians’ legal protections which are reciprocal to their professional mandate and their duty to care for patients. Then, if physicians are expected to have the responsibility to care about patients in a fiduciary way, this is reciprocal to the privileges they enjoy in society.³⁵⁷ As

³⁵¹ Derek Portwood and Alan Fielding, “Privilege and the professions”, *Sociological Review* 29 no. 4 (1981): 749-774,754.

³⁵² Ibid.

³⁵³ Ibid.

³⁵⁴ Ibid.

³⁵⁵ Ibid, 768-769.

³⁵⁶ Ibid, 758.

³⁵⁷ Claire Zilber, “Ethics and the doctor–patient relationship”, Brown University, https://www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/ETHICS%20AND%20THE%20DOC%20TOR.pdf

explained later, physicians' responsibility to care and promote the welfare of their patients encompasses the participation of physicians in advocacy actions to promote the health of undocumented immigrants.

The social standing of doctors is also based on their scientific expertise, as their opinions are observed to be based on medical knowledge, evidence and data.³⁵⁸ Medicine has a specific rhetoric and methodology that puts medical arguments in a position of relevance and higher credibility, as expert opinions are perceived as unbiased and neutral. This credibility allows physicians to have "political maneuvering" and a bigger chance to be involved in policy making and other political choices that require expert opinions and evidence to justify certain decisions.³⁵⁹

Finally, physicians' status is enhanced by and reflected in the way society perceives their role and opinions. Their ideological and cultural influence has given them the status to influence "moral standards and choices of society-the role of elite"³⁶⁰. Doctors also enjoy a generalized social respect and recognition, which is linked to the tradition of the profession and unique expertise.³⁶¹ This social relevance provides them with "(...) political power, professional and

³⁵⁸ It is important to note that medicine's objectivity has been challenged by different authors that have explained how the medical discourse cannot be understood in a vacuum and has been a result of moral, social and economic anxieties, its neutral character is still maintained in society. See: Michel Foucault, *Madness and Civilization. A History of Insanity in the Age of Reason*, translated by Richard Howard (New York: Vintage Books, 1988). Also see: Anne Fausto-Sterling, *Myths of gender: biological theories about women and men* (New York: BasicBooks, 1992; Barry Barnes, *Scientific Knowledge and sociological theory* (London: Routledge & Kegan Paul, 1974).

³⁵⁹ Mark A. Earnest, Shale L. Wong and Steven G. Federico, "Perspective: Physician advocacy: what is it and how do we do it? *Acad Med*, 85 no 1 (Jan 2010): 63-67.

³⁶⁰ *Ibid*, 64.

³⁶¹ *Ibid*.

public prestige, and more remuneration than other professions”³⁶². These benefits might also include privileged access to people in positions of power, such as politicians and decision makers. This a crucial point for advocacy actions, as the credibility and social relevance of the spokesperson is crucial to influence decision makers and the general public.

3.2.2 Physician’ unique access to patients’ health

Physicians find themselves in a favorable position to advocate for immigrants’ health, as they have an exceptional access to their physical and mental state and needs, and they can evidence the marks and consequences that the process of migration and the policies that have targeted them have left. This can happen through individual medical consultation or through medical research that targets the health of immigrants.

In the individual medical consultation scenario, it is common for physicians to discover certain characteristics of undocumented immigrants’ health. This can be done through immigrants’ medical records, their testimonies or the signs and symptoms. For example, physicians that work in detention centers have unique access to the conditions in which immigrants arrive in the country and how their health can be affected by their living conditions in the centers. Deborah Zion highlights how physicians can bear witness and bring to light the conditions of incarceration and its health consequences.³⁶³ In the context of refugee seekers in Australia, she highlights how

³⁶² Wendy Lipworth, Miles Little, Pippa Markham, et all, “Doctors on status and respect: A qualitative study” *J Bioethical Inquiry*, 10 no 2(2013): 205-217, 206.

³⁶³ Deborah Zion, “On beginning with justice: Bioethics, advocacy and the rights of asylum seekers”, *Bioethics, Special Issue: Advocates and Activists*, 33 (2019) :890–895.

physicians have been instrumental and crucial to “bringing to light the conditions of incarceration, and have advocated, both privately and publicly, for patients to be released.”³⁶⁴ In the same line, Louise Newman, an Australian physician states that physicians have the responsibility to document and communicate the health impacts of harmful migration policy, as “(...) this positive advocacy for voiceless and disempowered people is a fundamental tenant of medical practice.”³⁶⁵

In the context of US detention centers, some physicians have documented and raised their voices against the abuses they have witnessed against undocumented immigrants. Chanelle Diaz states “As a physician who has evaluated adults held in immigration jails, I have witnessed conditions in detention facilities that are unsafe for adults and deadly for children(...)”³⁶⁶ In the same line, some physicians have asked the government to release detained undocumented immigrants in order to prevent them from suffering from the consequences of the COVID-19 pandemic and the lack of prevention measures in detention centers. Recently three physicians stated “As physicians who work in New York City hospitals, we are witnessing how COVID-19 is ravaging the communities we serve. The only way to slow this pandemic is to stop the transmission of the disease. Yet despite everything we know about how the virus spreads and the unprecedented sacrifices workers have made to slow the spread, Immigration and Customs

³⁶⁴ Ibid, 892.

³⁶⁵ Ibid.

³⁶⁶ Chanelle Diaz, “The real border crisis: medical neglect of migrants in detention centers”, *Stat News*, January 10, 2019, <https://www.statnews.com/2019/01/10/medical-neglect-migrants-detention/>

Enforcement (ICE) continues to endanger the lives of over 40,000 immigrants in more than 200 jails and prisons nationally.”³⁶⁷

In the context of research, physicians and their unique knowledge are crucial to raise awareness about the health impacts on undocumented immigrants. Research can be understood as a way of advocacy as it can be a way to document health problems and abuses by using the scientific method. Deborah Zion explains that health research in the contexts of immigrants and refugee seekers can potentially promote social change and challenge structures and power relations.³⁶⁸ Medical research has contributed to understanding how certain policies and conditions can impact the health of undocumented immigrants. One example is research performed in order to analyze and compare the mental health of children of immigrant and non-immigrant parents. In 2016, the Developmental Pathways Project (DPP) of the Division of Child and Adolescent Psychiatry at the University of Washington and Seattle Children’s Hospital did a cross-sectional, epidemiological study and performed mental health screenings on children. In this study, they concluded that “Among Asian American/Pacific Islanders and Latinos, children of immigrants had significantly higher depression and disruptive behavior scores compared to non-immigrants.”³⁶⁹

Likewise, a group of physicians and researchers from the Harbor-UCLA Medical Center, Department of Emergency Medicine in Torrance, California published in 2019 a research paper in

³⁶⁷ Nathaniel Kretz, Channele Diaz and Xavier Pereira, “Immigration detention is a public health hazard”, *New York Daily News*, May 2020, <https://www.nydailynews.com/opinion/ny-oped-immigration-detention-public-health-hazard-20200507-meszox56jhlplaxnj6loujci-story.html>

³⁶⁸ Deborah Zion, “On beginning with justice: Bioethics, advocacy and the rights of asylum seekers”, *Bioethics, Special Issue: Advocates and Activists*, 33 (2019) :890–895, 891.

³⁶⁹ Jahum Kim, Semret Nicodimos, et al, “Comparing Mental Health of US Children of Immigrants and Non-Immigrants in 4 Racial/Ethnic Groups”, *Journal of School Health*, 88 no 2 (February 2018): 167-175, 170.

which they document and show the barriers that undocumented patients face in the Emergency Department. They propose an “immigration-informed emergency department” which includes the recognition of immigration as a modifiable social determinant of health, promoting immigration informed interventions and advocacy.³⁷⁰ They conclude: “By bearing witness to the human impact of anti- immigration legislation on patient health, ED providers make excellent advocates on the local and national level.”³⁷¹

3.3 Arguments against physicians advocating for the health of undocumented immigrants

Finally, it is crucial to address the reasons why some authors have objected to physicians’ advocacy. Some authors have challenged the role of physicians in advocacy work, citing factors such as time demands and lack of skills. Thomas Huddle is one of the main detractors of physicians’ advocacy. According to him, advocacy is a noble cause, but “must remain an occasional and optional avocation in academic medicine, not a universal and mandatory commitment.”³⁷² He provides different arguments to justify the view that even if advocacy has been included as part of medical professionalism, it should not be considered part of the professional and ethical scope of physicians and can even harm physicians and patients relationship.

³⁷⁰ Shamsher Samra, Breena R. Taira, Erika Pinheiro, et al, “Undocumented Patients in the Emergency Department: Challenges and Opportunities” *Western Journal of Emergency Medicine*, 20, no. 5 (2019): 791-798.

³⁷¹ *Ibid*, 795.

³⁷² Thomas S Huddle, “Perspective: Medical professionalism and medical education should not involve commitments to political advocacy”, *Acad Med*. 86 no 3 (march 2011): 378–383, 378.

First, Huddle explains the dangers of politicizing the medical profession, citing the risk of physicians losing their special authority as “medical engagement with politics will displace real medical work, which is the only contribution of medical professionals, as such, to societal betterment.”³⁷³ So, he questions why physicians have to spend time doing advocacy work and “may not legitimately prefer whatever activities they please to politics.”³⁷⁴ Likewise, he claims that advocacy should not be considered part of the doctor– patient relationship. However, as it was expressed in this thesis, advocacy actions expected from physicians are not external to their own knowledge and expertise, nor are they unrelated with the physician-patient relationship.

Jeannine Banack responds to Huddler article by arguing that “Advocacy by physicians does not mean that physicians become politicians. It means that they are sufficiently aware of the determinants of health, as well as problems and resources in the specific communities where their practices are located, to know when a situation requires them to become advocates for the individual or collective well-being of their patients.”³⁷⁵ Thus, to suggest a disjunction between professional duties and advocacy creates a false dichotomy as physicians might be involved in advocacy through research, patient empowerment, among other activities that are tied to their core actions and goals. Advocacy actions can be fed by the clinical encounter with undocumented patients, as it is precisely this individual interaction that can provide evidence to promote better care for this population. It is also necessary to question what is in fact “real medical work”,

³⁷³ Thomas S Huddle, “Perspective: Medical professionalism and medical education should not involve commitments to political advocacy”, *Acad Med.* 86 no 3 (March 2011): 378–383, 379.

³⁷⁴ *Ibid.*

³⁷⁵ Jeannine Banack, “Do Medical Professionalism and Medical Education Involve Commitments to Political Advocacy?”, Letters to the Editor, *Acad Med.* 86 no 9 (September 2011):1064-1065.

specially, in a context in which physicians can contribute to the medical profession by engaging in a wide range of activities, including medical research, clinical work, education, and administrative tasks.

Second, Huddle maintains that political advocacy should not be considered a professional duty or virtue, but a civic one.³⁷⁶ Accordingly, physicians cannot be required to be good “citizens” as part of their professional imperatives. Responding to this claim, a group of pediatric residents from the Department of Pediatrics at University of California maintained that it was not through their citizenship that they were able to understand the difficulties many of their patients were facing and developed better ways to address them. They claimed that “(...) it was our profession and our patients that granted us privileged insight into these conditions. Accordingly, it must remain our professional mandate to use advocacy to address these challenging situations.”³⁷⁷ Also, they explained how limiting their scope to individual patient advocacy and not being involved in collective actions to promote the health of patients would prevent them from looking for “upstream solutions to avoid downstream problems.”³⁷⁸

This work has made it clear that when physicians participate in advocacy for the health of undocumented immigrants they are acting on their specific role as physicians, acknowledging their unique positions, recognizing their role in past injustices and contributing to restore and tackle the structural health injustice that this population faces. It is precisely because physicians have a

³⁷⁶ Thomas S Huddle, “Perspective: Medical professionalism and medical education should not involve commitments to political advocacy”, *Acad Med.* 86 no 3 (March 2011): 378–383, 379.

³⁷⁷ Sohil R. Sud, Elizabeth S. et al, “Do Medical Professionalism and Medical Education Involve Commitments to Political Advocacy?”, Letters to the Editor, *Acad Med.* 86 no 9 (September 2011): 1064-106.

³⁷⁸ Ibid, 1061.

privileged access to immigrants' health and needs and have a prestige in society that their actions will be more effective. Moreover, as the section about justice expressed, the medical profession has a responsibility with injustices against immigrants that has perpetuated health inequalities and their stigmatization. Then, the medical profession should work to restore the relationship of trust with immigrants and advocacy is an effective way on which the profession can repair past harms and contribute to address the health injustice they are facing. Hence, even if advocacy can indeed be understood as civic duty, there are specific reasons to defend advocacy actions from physicians.

Third, Huddle argues that advocacy might require physicians to take a stand and defend a particular political position which is usually aligned with statements such as "health for all". Thus, Huddle reasons that "(..)it cannot be proper that the profession of medicine demand a particular political stance of its members (i.e., any one stance in the universe of acceptable political stances)."³⁷⁹ In the same line, another objection maintains that when physicians get "too political" there might be a possible interference with the therapeutic alliance between the physician and the patient.³⁸⁰ Justin Rossi explains that "if physicians as a profession advocate for specific policies they run the risk of being seen as narrow-minded or mischaracterized as yet another interest group competing in the political arena."³⁸¹ This perception can jeopardize public trust of physicians and question their neutrality and objectivity.³⁸² Responding to this, Sarah Dobson states that doctors

³⁷⁹ Thomas S Huddle, "Perspective: Medical professionalism and medical education should not involve commitments to political advocacy", *Acad Med.* 86 no 3 (March 2011): 378–383, 380.

³⁸⁰ Justin Rossi, "The Challenge of Physician Civic Engagement: Promoting Health While Preserving Public Trust", *AMA Journal of Ethics*, 16, no 1(2014) 896-900.

³⁸¹ *Ibid*, 897.

³⁸² *Ibid*.

are trained to keep their political preferences and opinions “out of the medical encounter.”³⁸³ In the specific case of advocacy for undocumented immigrants, the polarized political climate around immigration policies in both the United States and Colombia might contribute to a context in which physicians fear patients will disagree with their views. They also fear that advocating for the health of undocumented immigrants might create difficult situations with patients who have political opinions against immigration and support the policies and measures that restrict immigrants from accessing health care or entering the country.

To address this objection, it is important to question if there is such a thing as political neutrality in the field of medicine. Medicine cannot be considered a purely objective and non-political field of knowledge. Even if physicians work with a scientific method that provides biological certainties, this does not mean that medicine as a profession should present as “politically neutral”. In some contexts, defending science, the medical profession and the improvement of health might be considered a political statement; and the core goals of medicine are not “value neutral”.

Moreover, physicians are entitled to have and act on political and ethical beliefs and are free to engage in advocacy and political activities that transcend the office, as any other professional. Discussing their views or trying to persuade their patients about certain political posture is another matter. Physicians’ advocacy should not involve an attempt to badger patients or try to convince them to change their political views. For example, physicians can be active members of the ACLU or Physicians for Human Rights, campaign, participate in drafting letters or be active on social media and newspapers, and sign petitions even if some of their patients

³⁸³ Sarah Dobson, Stéphane Voyer and Glenn Regehr, “Perspective: Agency and Activism: Rethinking Health Advocacy in the Medical Profession”, *Academic Medicine* 87, no. 9 (September 2012) 1161-1164, 1162.

disagree with these views and would “fire” the physician if they were to learn of their views. This situation would be very different if physicians would start using patients’ information to send petitions or use consultation time in order to persuade them into participating in these activities. In this case, it is important to differentiate between physician advocating to patients and advocating for patients. The definitions and examples of advocacy for the health of undocumented immigrants that I have provided in this thesis are examples of physicians advocating for patients, and should not be understood as an inappropriate interference.

Lastly, participating in advocacy, far from breaking the relationship of trust with patients, can strengthen the physician and patient alliance as physicians’ skills can be strengthened and patients can be confident that their physicians will defend their interests and their health, even in difficult political contexts and without caring who they are. Advocacy can contribute to improve physicians’ empathy and leadership, and enable them to better assess their patients’ needs. And as a group of physicians responded to Huddle, “(...) we harm our virtue and our patients so much more by refusing to stand up for them on public matters of health.”³⁸⁴

³⁸⁴ Adam Schickedanz, Katherine Neuhauser, et al, “Do Medical Professionalism and Medical Education Involve Commitments to Political Advocacy?”, Letters to the Editor, *Academic Medicine* 86 no 9 (September, 2011): 1064-1065, 1062.

4.0 Case studies of physicians who advocate for immigrants' health in the United States and Colombia

In this section, with the aid of case studies, I offer examples of how physicians in the United States and Colombia have acted as advocates for the health of undocumented immigrants. First, I discuss the case of Sanctuary Doctoring, which following the ideas of the sanctuary movement, proposes a model and approach to medical care for undocumented immigrants. Second, I analyze the case of Physicians for Human Rights, which works in different parts of the world to advocate against human rights violations. Specifically, I analyze their initiatives related with refugees and immigrants in the United States. Finally, I study the case of Profamilia, a sexual and reproductive health provider which has advocated for the needs of Venezuelan undocumented immigrants in Colombia.

Physicians' advocacy has been more developed in the United States than in Colombia. This is reflected in the existence of well established initiatives such as Physicians for Human Rights and the incorporation of advocacy as part of the medical curriculum, the American Medical Association's (AMA) inclusion of advocacy as part of the Declaration of Professional Responsibility, among other things. The situation is not similar in Colombia. Although some Colombian physicians are involved in advocacy actions, there are not many visible physician-based initiatives that promote advocacy in general, or specifically for undocumented immigrants. In fact, physicians' advocacy has been more focused on lobbying by medical associations and NGO's that work with health professionals. This is why I have only chosen one case study from Colombia and focused on two case studies from the United States. I believe this thesis can help

physicians from Colombia to see examples of physicians' advocacy and inspire them to develop more advocacy work for the health of Venezuelan immigrants in the future.

Although these three case studies are examples of physicians' advocacy, they also involve the efforts of other health professionals such as nurses, psychologists and health administrators. The success of these initiatives requires the participation of different professionals, including a different range of health professionals. I recognize the importance of all professionals' efforts to advocate for the health of undocumented immigrant, but the analysis of this thesis is limited to the ethics of physicians' advocacy. Even if the ethical framework for health professionals can have similarities, it is necessary to provide a differentiated and adequate analysis for each health professional, as their goals and scope of action is very different. This can certainly be an opportunity to further this analysis.

4.1 Sanctuary doctoring

The term sanctuary has been used to name places that are protected and safe for undocumented immigrants. Norma Stoltz and Nora Hamilton write about the Sanctuary Movement that was led by religious leaders who organized to protect undocumented immigrants and refugee seekers from Central America in the 1980's.³⁸⁵ Specifically, the exodus was a result of the wave of authoritarian violence in Guatemala and El Salvador that caused the immigration of many social leaders to the United States. These refugee seekers faced persecution and harassment from

³⁸⁵ Norma Stoltz Chinchilla, Nora Hamilton, and James Loucky "The Sanctuary Movement and Central American Activism in Los Angeles", *LATIN AMERICAN PERSPECTIVES*, 169, 36 no. 6 (November 2009): 101-126.

immigration authorities.³⁸⁶ As a response, religious leaders started to use the term “sanctuary” to reflect the status of churches and religious places where immigrants could find a place of protection from immigration authorities. The first case can be traced to Tucson, Arizona where a Presbyterian Minister decided to protect undocumented Salvadoran immigrants in his church.³⁸⁷ After the declaration of “sanctuary churches” throughout Los Angeles, schools started to add this label to their institutions in order to show their intention to protect and support undocumented immigrants.³⁸⁸ Afterwards, some cities started using the same term in order to express their unwillingness to cooperate with immigration authorities. In February of 1985 the city of Berkeley “(...) declared itself a city of refuge: city employees would not cooperate with the INS in investigations or arrests of Salvadoran and Guatemalan refugees”.³⁸⁹ Subsequently, many other states and cities have formalized their sanctuary status and enacted legislation that specifically declares they won’t cooperate with immigration authorities to prosecute or capture undocumented immigrants.³⁹⁰

Hospitals and clinics started using the term to denote the status of their institutions. The terms *sanctuary doctoring* or *sanctuary hospitals* started to become more common after the recent wave of reported raids and deportations in hospitals.³⁹¹ As described before, during the Trump administration immigration authorities have used health facilities to capture undocumented

³⁸⁶ Ibid.

³⁸⁷ Ibid, 105.

³⁸⁸ Ibid, 116.

³⁸⁹ Ibid, 117.

³⁹⁰ Ibid.

³⁹¹ Altaf Saadi, Sameer Ahmed and Mitchell H. Katz, “Making a Case for Sanctuary Hospitals”, *JAMA* 318, no 21 (December,2017): 2079-2080.

immigrants. According to Altaf Saadi, immigration enforcement at or near health facilities has increased during the last 4 years. Even if hospitals have been understood as “sensitive locations” where immigration enforcement has been traditionally avoided, the Trump administration disregarded this practice.³⁹² Similarly, in Colombia there are reported cases of administrative authorities at hospitals and clinics that threaten undocumented Venezuelans and pressure them to pay their bills.³⁹³ As argued earlier, using medical settings to enforce immigration regulations can adversely affect the health of undocumented immigrants. These harmful effects can include the development of preventable diseases, high levels of fear, and stress and anxiety.³⁹⁴

In this adversarial context, medical institutions and physicians have started to reject the use of medical institutions as places to enforce immigration policies. In the United States, an increasing number of hospitals have started using the term “sanctuary” and adopting policies to protect undocumented immigrants, including their information and their legal status.³⁹⁵ Mark Kuczewski and his team at Loyola University define *sanctuary doctoring* as a combination of strategies that include “the emotional support of an empathetic physician-patient relationship with patient empowerment by supporting patient networking and identifying helpful actions the patient can

³⁹² Ibid, citing Morton J. US Immigration and Customs Enforcement—enforcement actions at or focused on sensitive locations. ICE, 2011, <https://www.ice.gov/doclib/ero-outreach/pdf/10029.2-policy.pdf>

³⁹³ I found out this information during my practicum at the legal clinic for immigration at Universidad de los Andes, where I did my bioethics program practicum in June of 2020.

³⁹⁴ Hacker K, Chu J, Leung C, et al. “The impact of Immigration and Customs Enforcement on immigrant health: perceptions of immigrants in Everett, Massachusetts, USA”, *Soc Sci Med.* 73 no 4 (2011): 586-594.

³⁹⁵ Altaf Saadi and Martin McKee, “Hospitals as places of sanctuary”, *BMJ* 361(2018) ,1.

take.”³⁹⁶ Loyola University proposes a number of strategies and a toolkit that could be adapted to hospitals and clinics in order to support a sanctuary doctoring model.³⁹⁷ This model promotes a dialogue between physicians and undocumented immigrants in order to increase their rights knowledge through the dissemination of translated information and networking with advocacy and human rights allies.³⁹⁸ Moreover, in order to overcome the chilling effect of recent immigration policies, this sanctuary doctoring model promotes the importance of talking with patients about their immigration situation and reassuring immigrants that their confidentiality will be respected. The model proposes a set of messages to be included in lapel pins, brochures and dialogues from the clinic staff such as “I will not write your immigration status in the medical record. Only health-related issues will be recorded;” or “Many people are going through similar struggles right now. You are not alone.”³⁹⁹ This model has also recommended that physicians provide support to undocumented immigrants to construct an emergency plan for themselves and their children in case they face sudden deportation.⁴⁰⁰

³⁹⁶ Mark Kuczewski, Johana Mejias-Beck and Amy Blair, “Good Sanctuary Doctoring for Undocumented Patients”, *AMA Journal of Ethics* 21 no 1 (January, 2019):E78-85, 79, <https://journalofethics.ama-assn.org/article/good-sanctuary-doctoring-undocumented-patients/2019-01>

³⁹⁷ Johana Mejias-Beck, Mark Kuczewski and Amy Blair, “Treating Fear: Sanctuary Doctoring” Toolkit, June 2018, <https://hsd.luc.edu/media/healthsciencesdivision/bioethics/documents/Sanctuary-Doctoring-presentation-June2018.pdf>

³⁹⁸ Mark Kuczewski, Johana Mejias-Beck and Amy Blair, “Good Sanctuary Doctoring for Undocumented Patients”, *AMA Journal of Ethics* 21 no 1 (January, 2019): E78-85, 79, 80.

³⁹⁹ *Ibid.*

⁴⁰⁰ *Ibid.*, 81.

There are other examples of sanctuary doctoring in the United States. In New York City, the Health and Hospitals integrated health care network promotes the message “Seek care without fear”.⁴⁰¹ Since December of 2016, this network of clinics issued an open letter to all immigrants in New York and specifically told them “Do not be afraid to go to the doctor, the clinic, the hospital, or the emergency room. All immigrants can get medical care in New York City, regardless of immigration status or ability to pay. We want you to seek care in any setting without fear.”⁴⁰² Also, they highlighted that all immigrants’ health information is completely confidential and that they can connect undocumented immigrants with other social and legal services.⁴⁰³ Another example of sanctuary doctoring is the Monsignor Oscar A. Romero Clinic in Los Angeles. This clinic was founded in 1983 by a group of Salvadorian refugees who promoted a health model that was compassionate with undocumented immigrants. The clinic has reported that almost 50% of their patients are undocumented and that after 2017 many started canceling their regular appointments as a result of their fear of immigration authorities.⁴⁰⁴ As a result, the clinic declared as a sanctuary and promoted a protocol to address possible visits from ICE. Particularly, the clinic has stated that “In the event of an ICE visit, the staff announce the agents’ presence by means of an unidentified code and immediately close the facility. Patients who could be targeted are moved

⁴⁰¹NYC Health + Hospitals, “Seek care without fear”, accessed November 15, 2020, <https://www.nychealthandhospitals.org/immigrant/>

⁴⁰²NYC Health + Hospitals, “Open Letter to Immigrant New Yorkers”, December 2016- Reissued April 2019, https://hhinternet.blob.core.windows.net/uploads/2019/04/immigrantCampaign_LetterFlyer.pdf

⁴⁰³ Ibid.

⁴⁰⁴ Jacqueline García and Virginia Gaglianone, “Sanctuary clinics offer respite for undocumented residents amid immigration raids”, *Center for Health Journalism*, September, 2019, <https://centerforhealthjournalism.org/sanctuary-clinics-offer-respite-undocumented-residents-amid-immigration-raids>

from the reception area to other parts of the clinic restricted to staff.”⁴⁰⁵ Also, the clinic promotes “health education and community advocacy on behalf of the under-served men, women and children of the Greater Los Angeles area.”⁴⁰⁶

The sanctuary doctoring model is an example of medical advocacy as it aims to promote the improvement of the health conditions of an underserved population. This initiative promotes the removal of obstacles to health care access as well as obstacles to successfully navigating the health care system. Sanctuary doctoring has helped to assure that immigrants will not avoid health institutions, as fear has been identified as one of the obstacles to seeking emergency services. Moreover, sanctuary doctoring has proved to be an effective strategy to improve the quality of care undocumented immigrants receive. A recent study about Mexican immigrants with diabetes in the San Francisco Bay Area and Chicago, shows that in sanctuary settings undocumented immigrants face fewer social burdens, stigma and barriers associated with their legal status.⁴⁰⁷ It was reported that in safer spaces without such barriers, diabetic patients seem to have better patient doctor interaction, better self-care practices and better clinical outcomes.⁴⁰⁸ The authors conclude that in safer settings, the quality of doctor-patient interactions experienced by undocumented patients is comparable to what immigrants with a legal immigration status experience.⁴⁰⁹ Sanctuary doctoring aims to restore the social bond and the trust that has been lost in undocumented patients.

⁴⁰⁵ Ibid.

⁴⁰⁶ Monsignor Oscar A. Romero Clinic, “Who we are”, accessed November 19, 2020, <https://clinicaromero.com/>

⁴⁰⁷ Elizabeth Iten, Elizabeth A. Jacobs, et al, “Undocumented Immigration Status and Diabetes Care Among Mexican Immigrants in Two Immigration “Sanctuary” Areas”, *J Immigrant Minority Health* 16 (2014) :229–238

⁴⁰⁸ Ibid.

⁴⁰⁹ Ibid.

Specifically, sanctuary doctoring can potentially “allow for hospital administrators and health care providers to create trust in the local immigrant community”⁴¹⁰.

Furthermore, promoting a safe medical environment and tackling the barriers that undocumented immigrants face can be understood as both an example of individual patient advocacy and as a form of collective advocacy and activism. On the one hand, sanctuary doctoring guarantees better care for individual undocumented patients by providing accessible information and sending messages that warranty their privacy and trust. Besides, this model promotes patients’ empowerment, by actively promoting information about immigrants’ rights and connecting them with advocacy groups and other resources that might contribute with their overall situation. As Kuczewski suggests, sanctuary doctoring promotes an “empathetic physician-patient relationship with patient empowerment by supporting patient networking and identifying helpful actions the patient can take”⁴¹¹ In this way, this model understands physicians as advocates of their undocumented patients and provides them with concrete tools and strategies to strengthen their agency and knowledge about their rights.

On the other hand, sanctuary doctoring is a way of promoting a more systemic approach. Kuczewski claims that “sanctuary doctoring works on the precept that health care should be a safe environment that provides support and resources to help patients deal with chronic stress and its sources.”⁴¹² Following this, sanctuary doctoring as a approach to medicine can have a structural impact since it promotes a methodology that recognizes and encourages an active conversation

⁴¹⁰ Ibid, 230.

⁴¹¹ Mark Kuczewski, Johana Mejias-Beck and Amy Blair, “Good Sanctuary Doctoring for Undocumented Patients”, *AMA Journal of Ethics* 21 no 1 (January, 2019): E78-85, 79.

⁴¹² Ibid.

about the social determinants of health. Hence, this model can be used for other populations that suffer the consequences of health disparities and face discrimination on a daily basis. Also, sanctuary doctoring can contribute to the construction of “a more humane narrative concerning undocumented immigrants”.⁴¹³ Physicians are crucial to revise the narrative used to describe undocumented immigrants, so they might help society and decision makers to remove the stereotypes and provide a better understanding of the realities and health challenges that undocumented immigrants face. Finally, as Saadi and McKee suggest, sanctuary doctoring can be a strategy to advocate for a more ethical understanding of the medical encounter that considers “(..) medical ethical principles and values of compassion and a right to healthcare, regardless of background.”⁴¹⁴ This, as good practices in health care can also be a way of advocating for the health of a vulnerable population.

4.2 Physicians for Human Rights

Physicians for Human Rights-PHR is another important example of physicians’ coordinated advocacy for immigration related issues. It was founded by a group of physicians that understood their voices could be highly important to uncover and stop human rights violations. PHR’s philosophy and aims were inspired by its founding members who were involved in forensic examinations during the Chilean dictatorship, South African Apartheid and Guatemalan and South

⁴¹³ Mark Kuczewski, John D. Lantos, Zarna Patel, “Advocating for the DREAM Act: Why Pediatricians Should Care and What They Can Do”, *Pediatrics.*, 141 no 1 (2018), 2.

⁴¹⁴ Altaf Saadi and Martin McKee, “Hospitals as places of sanctuary”, *BMJ* 361(2018), 2.

Korean human rights violations.⁴¹⁵ This organization promotes the connection of medical ethics with human rights defense. It uses “(..) core disciplines – science, medicine, forensics, and public health – to inform our research and investigations and to strengthen the skills of frontline human rights defenders.”⁴¹⁶ Also, PHR works “(...) closely with hundreds of partners around the world, using facts to wage effective advocacy and campaigning and providing critical scientific evidence so that survivors can seek justice.”⁴¹⁷ PHR specifically states that it is through the “Authoritative voices of medical professionals” that they want to advocate for vulnerable populations.⁴¹⁸ With their voices, PHR promotes three types of work: i) advocacy; ii) forensic documentation and iii) empowerment.

In the case of forensic documentation, PHR uses “(...) the power of science and forensic medicine to establish a fact-based record of human rights abuses.”⁴¹⁹ These forensic documentations understand that physicians are direct witnesses of human suffering and that medical data is crucial to evaluate and provide objective evidence in different contexts. Medical evidence of the physical and psychological state of asylum seekers is crucial for their legal applications, as this can help them prove that they are in fact escaping extreme situations of

⁴¹⁵ Physicians for Human Rights, “Our founders believed that health professionals are uniquely positioned to prevent serious human rights abuses”, accessed November 16, 2020, <https://phr.org/about/history/>

⁴¹⁶ Physicians for Human Rights, “About”, accessed November 16, 2020, <https://phr.org/about/>

⁴¹⁷ Physicians for Human Rights, “Global conflicts, civil wars, and injustice have driven immigration to an all-time high since 1990. Seeking asylum from persecution is a human right”, accessed November 16, 2020, <https://phr.org/issues/asylum-and-persecution/>

⁴¹⁸ Physicians for Human Rights, “We use our authoritative voice to protect human rights and end impunity for perpetrators”, accessed November 16, 2020, <https://phr.org/our-work/how-we-work/we-advocate/>

⁴¹⁹ Physicians for Human Rights, “About”, accessed November 16, 2020, <https://phr.org/about/>

violence and persecution and that their health and lives are in danger if they go back. Understanding this, PHR has developed an “Asylum Network” which includes 1,700 health professionals all over the United States that provide independent forensic medical evaluations for asylum seekers that can “document compelling evidence of physical and psychological trauma.”⁴²⁰ By providing accurate forensic evaluations for refugee seekers, PHR has guaranteed more successful outcomes in asylum applications and has protected more than 600 refugees in the United States.⁴²¹

Additionally, through the work of documentation, PHR has highlighted the different ways in which current immigration policies in the United States have particularly affected the health of undocumented immigrants, including asylum seekers. PHR has launched reports and fact sheets that have evidenced that: i) Detention can intensify ongoing experiences of trauma in immigrants who have escaped violence; and it can leave serious mental health consequences, which are especially harmful for children⁴²²; ii) Children who are currently seeking asylum in the United States have suffered sustained trauma in their countries of origin, in transit, when arriving at the border, and during detention. This is expressed in physical symptoms such as chronic pain, bruising, head injuries, neurocognitive damage and psychological trauma, among others⁴²³; iii) Pregnant Women in detention centers cannot access timely, appropriate or adequate medical care

⁴²⁰Physicians for Human Rights, PHR Asylum Program, accessed November 16, 2020, <https://phr.org/issues/asylum-and-persecution/phr-asylum-program/>

⁴²¹ Ibid.

⁴²² Physicians for Human Rights, “The Impact of Immigration Detention on Migrant Mental Health”, *PHR Issue Brief*, October 2018.

⁴²³ Physicians for Human Rights, “There Is No One Here to Protect You. Trauma among children Fleeing Violence in Central America”, *PHR Report*, June, 2019.

and might be subjected to stressful environments that affect their pregnancies⁴²⁴; and iv) Undocumented immigrants, including children, are facing adverse physical and mental health effects as a result of the family separation policy. These effects include symptoms of “post-traumatic stress disorder, major depressive disorder, and generalized anxiety disorder”.⁴²⁵

To document the ways in which immigration policies have impacted the health and lives of undocumented immigrants, PHR has used forensic work, field work, interviews, medical literature, and comparative research, among others. PHR has conducted this work with the support of physicians, social workers, trauma experts, and other health professionals and medical networks.⁴²⁶ In PHR’s “You Will Never See Your Child Again” report, physicians who are part of the PHR network performed forensic evaluations on 17 adults and 9 children who had been separated for an average of 60-69 days.⁴²⁷ Similarly, in the “There Is No One Here to Protect You” report, PHR medically evaluated “114 male and 69 female asylum applicants, with an average age of 15 at the time of evaluation”.⁴²⁸

PHR has provided an important number of evidence-based policy recommendations that include: i) the immediate elimination of the family separation policy and the reunification of

⁴²⁴ Physicians for Human Rights, “Health Harms Experienced by Pregnant Women in U.S. Immigration Custody”, *PHR Fact Sheet*, 2019.

⁴²⁵ Physicians for Human Rights, “You Will Never See Your Child Again. The Persistent Psychological Effects of Family Separation”, *PHR Report*, February 2020.

⁴²⁶ Ibid. Also see: Physicians for Human Rights, “There Is No One Here to Protect You. Trauma among children Fleeing Violence in Central America”, *PHR Report*, June, 2019

⁴²⁷ Physicians for Human Rights, “You Will Never See Your Child Again. The Persistent Psychological Effects of Family Separation”, *PHR Report*, February 2020.

⁴²⁸ Ibid.

families, specially of children who have been separated from their parents; ii) ensuring adequate care of all immigrants in detention centers, emphasizing pediatric medical screening on arrival and adequate gynecological care for pregnant women; iii) preventing children from being kept in holding cells for more than 24 hours and prioritizing community settings for minors and pregnant women; iv) investigating and guaranteeing accountability for reported cases of child abuse or any other form of violence against asylum seekers and immigrants in detention centers; v) providing reparations that include immediate mental health and medical care for families and minors who have been through family separation in the context of immigration, among others.⁴²⁹

PHR uses the information they document and collect to promote advocacy. In the case of immigration, their advocacy work has included mobilizing, calling to action, disseminating information and sending letters requiring immigration policies to change and highlighting the health consequences of immigration policies to local and federal decision makers.⁴³⁰ PHR has used different strategies to disseminate the documentation results and has actively promoted open letters and petitions to the United States Congress and immigration authorities. For example, PHR is currently urging citizens to send a letter to their representatives to promote the approval of the “Federal Immigrant Release for Safety and Security Together Act”. This act recognizes the need to release immigrants and asylum seekers from detention centers in order to protect their health

⁴²⁹ Physicians for Human Rights, “There Is No One Here to Protect You. Trauma among children Fleering Violence in Central America”, *PHR Report*, June, 2019. Also see: Physicians for Human Rights, “You Will Never See Your Child Again. The Persistent Psychological Effects of Family Separation”, *PHR Report*, February 2020, Physicians for Human Rights, “Health Harms Experienced by Pregnant Women in U.S. Immigration Custody”, *PHR Fact Sheet*, Physicians for Human Rights, “The Impact of Immigration Detention on Migrant Mental Health”, *PHR Issue Brief*, October 2018.

⁴³⁰ Ibid.

and prevent a further expansion of COVID-19.⁴³¹ By November of 2020, 7,315 immigrants in custody have tested positive for COVID-19.⁴³² PHR has specifically provided their expert opinion to criticize legal measures that might endanger immigrants. On January of 2020 the organization explained why collecting DNA from detained immigrants is unethical and unnecessary from a medical perspective.⁴³³ Likewise, in July 2020, PHR expressed objections to “Rule 85 FR on Procedures for Asylum and Withholding of Removal; Credible Fear and Reasonable Fear Review”. This rule changed different concepts and parts of the process for asylum seekers. According to PHR, the Rule specifically: i) Creates high evidentiary standards and affects people who do not file for asylum within one year of arrival to the United States; ii) restricts the definitions of domestic violence, gang violence, sexual orientation, gender identity and persecution claims based on death threats; and iii) restricts who should be considered a public official in the context of torture.⁴³⁴ Responding to these changes, the organization reasoned that, “By denying due

⁴³¹ Physicians for Human Rights, “Act Now: Urge Your U.S Representatives to Support the FIRST Act”, https://secure.phr.org/urge-your-representatives-to-support-first-act?utm_term=phr_sitebanner

⁴³² The American Bar Association, “Impact of COVID-19 on the Immigration System”, accessed March 2, 2021, https://www.americanbar.org/groups/public_interest/immigration/immigration-updates/impact-of-covid-19-on-the-immigration-system/

⁴³³ Physicians for Human Rights, “U.S. Government’s New Program to Collect DNA from Detained Migrants is Unethical and Unnecessary: PHR”, press release, January 8 of 2020, <https://phr.org/news/u-s-governments-new-program-to-collect-dna-from-detained-migrants-is-unethical-and-unnecessary-phr/>

⁴³⁴ Physicians for Human Rights, “Comment on 85 FR 36264 [RIN 1125-AA94; EOIR Docket No. 18-0002; OMB Control Number 1615-0067] Procedures for Asylum and Withholding of Removal; Credible Fear and Reasonable Fear Review”, July 15 of 2020, <https://phr.org/wp-content/uploads/2020/07/Physicians-for-Human-Rights-Public-Comment-on-Asylum-Rule-July-15-2020-2.pdf>

process and narrowing the definitions of persecution and torture, this Rule violates the right to seek asylum and U.S. obligations under international treaties and domestic law. The proposed changes in U.S. regulations will return many asylum seekers to grave harm or death in their home countries.”⁴³⁵ PHR used cases of asylum seekers handled by their network to show how the restrictions on time and definitions on asylum brought by the rule will only affect the most vulnerable adults and children and do not respond to the realities of human rights violations in different countries.⁴³⁶

Finally, in the context of empowerment, PHR focuses its work on enabling and providing the tools to physicians and other medical professionals so they are able to “collect, analyze, preserve, and use credible evidence to expose and stop human rights abuses.”⁴³⁷ PHR provides training for health professions and develops partnerships with medical schools and advocates. Also, PHR has different pedagogical materials to guide forensic evaluations for asylum seekers, emphasizing how to document the traumatic experiences of adolescents, unaccompanied children, LGBTQ people and immigrants that have experienced political persecution and torture.⁴³⁸

Overall, PHR is an advocacy organization that understands the importance of medical and scientific knowledge and uses it to prevent human rights violations around the world. Initiatives like PHR illustrate how physicians can use their unique position to advocate for the health and

⁴³⁵ Ibid.

⁴³⁶ Ibid.

⁴³⁷ Physicians for Human Rights “We enable front line human rights defenders to expose violations and hold perpetrators accountable”, accessed November 17, 2020, <https://phr.org/our-work/how-we-work/we-empower/> .

⁴³⁸ Physicians for Human Rights, “Guides and Protocols for Clinicians”, Asylum Network Resources, accessed November 17, 2020, <https://phr.org/issues/asylum-and-persecution/asylum-network-resources-linked/>

well-being of all people and to speak out against policies that can potentially harm undocumented immigrants and other vulnerable populations. As Jonathan Fine, one of the cofounders of PHR said “I saw the tremendous impact ... how we could change a government’s behavior, and [felt] that as physicians we had a special responsibility to prevent the horror of torture and degradation of our skills in the aid of torturers”⁴³⁹. For PHR it is clear that providing scientific arguments and accurate data will enable governments, societies and the medical profession to adopt evidence-based policies that will promote the health and well-being of undocumented immigrants.

4.3 Profamilia-Colombia

Profamilia is the largest sexual and reproductive health services provider in Colombia.⁴⁴⁰ Apart from having a large network of clinics, Profamilia has research, advocacy and comprehensive sexual educational programs that aim to guarantee the sexual and reproductive rights of the Colombian population. In fact, it is through the information gathered in the provision of services in 25 cities of Colombia that the organization runs other lines of work, promoting an “expert, useful and practical voice that works for the guarantee of Human Rights from a gender and diversity perspective.”⁴⁴¹ As a private organization, Profamilia mobilizes resources from national and international sources in order to support social projects and health services that are

⁴³⁹ Physicians for Human Rights, “Our founders believed that health professionals are uniquely positioned to prevent serious human rights abuses”, accessed November 17, 2020, <https://phr.org/about/history/>

⁴⁴⁰ (Translated by the author) Profamilia, “about”, accessed November 17, 2020, <https://profamilia.org.co/somos/>

⁴⁴¹ Ibid.

not covered by the state for vulnerable populations.⁴⁴² In order to cover the needs of the immigrant population that has massively arrived in Colombia since 2016, Profamilia has developed two strategies: i) comprehensive essential humanitarian sexual and reproductive health provision and ii) research to document the unmet sexual and reproductive health needs of Venezuelan immigrants in order to impact decision making around the immigration phenomenon.

Undocumented women experience many barriers to access sexual and reproductive health services, as contraceptive methods, abortions or preventive exams for breast and cervical cancer have not been included under the scope of “medical urgency”.⁴⁴³ Specifically, Venezuelan undocumented women experience many barriers to access abortion services, which are legal in the country since 2006. In Colombia women are able to legally access free abortion services when the pregnancy is a result of sexual violence, is a threat to a woman’s health or life, or when the fetus has a malformation that is incompatible with life.⁴⁴⁴ However, abortion has only been considered a medical urgency when it is part of a sexual violence protocol.⁴⁴⁵ Therefore, the Colombian health system would only cover abortions for Venezuelan immigrants when they are considered victims of sexual violence and the hospitals have activated the appropriate protocol.⁴⁴⁶ Even if many Venezuelan women are in fact victims of sexual violence in the context of their migration process, especially when they get to the country through informal routes, many of them

⁴⁴² Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar* (Bogota: IPPF, 2019)

⁴⁴³ Ibid.

⁴⁴⁴ (Translated by the author) Constitutional Court of Colombia, ruling C-355 of 2006.

⁴⁴⁵ (Translated by the author) Ministry of Health and Social Protection, Resolution 459 of 2012.

⁴⁴⁶ Ibid.

are not willing to report the attacks they suffer.⁴⁴⁷ For this reason, many cases of sexual violence are not reported and the health system doesn't consider many pregnancies to be a result of sexual violence.

Considering this situation, Profamilia has mobilized resources from international sources in order to subsidize reproductive health services for Venezuelan immigrants in the frontier between Colombia and Venezuela and other recipient cities in Colombia.⁴⁴⁸ These services include long-term contraceptive methods, gender-based violence prevention and attention, psychological counseling and basic medical attention for pregnancy, childbirth, and postnatal care. Moreover, the organization provides “prevention and care programs for unintended unplanned pregnancies, particularly through safe abortion procedures (pharmacological with Mifepristone and Misoprostol, but also via manual vacuum aspiration) at any gestational age, in all its clinics.”⁴⁴⁹ In order to do this, the organization has strengthened their “installed capacity at the border and in other cities to meet the SRH [sexual and reproductive health] needs of migrants.”⁴⁵⁰ According to Juan Carlos Vargas, gynecologist and the Scientific Advisor of Profamilia, the service provision to the population of undocumented immigrants is related to the organization's commitment to the Hippocratic Oath and its modifications with the Geneva Convention in 1995 as “(...) doctors promise to defend life and... prevent any considerations of race, nationality, party or class to be

⁴⁴⁷ Profamilia, Colombia and IPPF, *Evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities of the Colombia-Venezuela border: Arauca, Cúcuta, Riohacha, and Valledupar*, (IPPF: Bogotá, D.C. 2019).

⁴⁴⁸ Ibid, 73.

⁴⁴⁹ Ibid.

⁴⁵⁰ Ibid, 74.

interposed between the duty of care and the patient. Part of the structure that every doctor must have is to think that the health of patients, regardless of who they are, must be assumed and faced to guarantee the person's well-being.”⁴⁵¹ Doctor Vargas states that “The doctor should always be thinking about advocacy especially for the ones that are more vulnerable in society and are not able to access health services to have a physical and mental well-being.”⁴⁵² Vargas also maintains that “Doctors advocate for their patients at different times and from different places during their career, it is their ethical duty and it is immersed in the medical profession.”⁴⁵³ Consequently, by mobilizing resources and adapting a special model to assess and support the needs of vulnerable undocumented immigrants, Profamilia is advocating for them so they can achieve their right to health in difficult humanitarian contexts.

The organization has not only focused on identifying and meeting those needs, but also documenting and publicizing them. This work has involved the medical team of their clinics in the country and the medical students who rotate through the clinics and have been able to better understand the needs of the migrant population, allowing their greater involvement and enabling them to share these experiences with their colleagues and teachers.⁴⁵⁴ Moreover, Profamilia has developed high quality research in the frontier which has highlighted the health disparities and problems the Venezuelan population is facing.⁴⁵⁵ In 2018, Profamilia with the support of the

⁴⁵¹ (Translated by the author) I interviewed Doctor Juan Carlos Vargas, the Scientific advisor of Profamilia on November 17, 2020. The interview was conducted on Spanish and I translated his quotes for this thesis.

⁴⁵² Ibid.

⁴⁵³ Ibid.

⁴⁵⁴ Ibid.

⁴⁵⁵ Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar*. (Bogota: IPPF, 2019.)

International Planned Parenthood Federation– IPPF, developed an evaluation of unmet sexual and reproductive health needs of the Venezuelan migrant population in four cities on the Colombia-Venezuela border.⁴⁵⁶ This assessment identified contraception, appropriate maternal attention, teen pregnancy, gender based violence prevention, and comprehensive sexuality education as the main needs of Venezuelan migrants and refugees in Colombia.⁴⁵⁷ Profamilia has highlighted attitudinal barriers, stereotypes, stigma and xenophobia among the most common obstacles that undocumented immigrants face to access reproductive health services.⁴⁵⁸ Considering these results, Profamilia recommended that the Colombian Minister of Health guarantee effective access to reproductive services for the immigrant community.⁴⁵⁹

In 2020, Profamilia researched health inequalities affecting Venezuelan immigrants and refugees with the Foreign Disaster Assistance of the United States (OFDA-USAID).⁴⁶⁰ Among the principle findings, the research confirmed existing inequalities, concentrated in higher rates of maternal mortality, HIV, higher risks and levels of sexual violence and barriers to receiving prenatal care, contraception and abortion services.⁴⁶¹ Also, the organizations concluded the extreme vulnerability of immigrants who are pregnant and adolescents as they face multiple

Also see: Profamilia, USAID, *Inequalities in health care utilization among Venezuelan migrants and refugees in Colombia How to strengthen the local response within the humanitarian emergency?* 2020. (Bogota: USAID, 2020)

⁴⁵⁶ Ibid.

⁴⁵⁷ Ibid.

⁴⁵⁸ Ibid.

⁴⁵⁹ Ibid.

⁴⁶⁰ Profamilia, USAID, *Inequalities in health care utilization among Venezuelan migrants and refugees in Colombia How to strengthen the local response within the humanitarian emergency?* 2020. (Bogota: USAID, 2020)

⁴⁶¹ Ibid.

challenges to access reproductive health, social exclusion, discrimination and higher risks of gender-based violence. Specifically, they highlighted the vulnerability of pregnant women due to lack of prenatal check-ups and how they “(...) are at risk of extreme maternal morbidity and gestational and congenital syphilis, problems that often result from the inefficient and uncoordinated provision of basic health services and from the first level of care.”⁴⁶²

Profamilia’s findings have been used to advocate for undocumented immigrants’ reproductive health with government officials and international donors. Specifically, Profamilia has advocated for the recognition of the rights of health of immigrants. In one of the reports, the organization invites the Colombia government to “move forward to ensure the mandatory nature of the right to health for the migrant and refugee population, where and when they need the services, particularly amid the health emergency due to COVID-19. The right to healthcare should not be denied based on the immigration status”⁴⁶³ Similarly, they have urged the state to “(...) reduce inequalities in the use of healthcare services, there is a need to consider all health-related determinants and work with all national and international players across clusters. Therefore, policies and responses within the humanitarian emergency are required to act on these determinants that create health inequalities before, during and after migration.”⁴⁶⁴ These recommendations have also been shared in academic events locally and nationally with the aim of contributing to the construction of sustainable solutions and policies.⁴⁶⁵

⁴⁶² Ibid, 110.

⁴⁶³ Ibid, 108.

⁴⁶⁴ Ibid, 109.

⁴⁶⁵ Ibid.

Profamilia's service provision is concerned with the specific needs of undocumented immigrants and their sexual and reproductive health. Also, by providing specific services for this population, the organization has been able to document the needs they witness and publicize them in order to recommend appropriate measures for decision makers. Rather than adopting government strategies to address the health situation of undocumented immigrants in Colombia, Profamilia has chosen to show how these measures are not enough and how actors should mobilize to advocate for better conditions for this extremely vulnerable population, disrupting 'business as usual,' and raising their voice against a health injustice.

With these three case studies, I have shown how physicians and medical-based organizations can advocate for the health of undocumented immigrants in the United States and Colombia. Without becoming experts on the law or public policy, physicians can participate in advocacy by using and taking advantage of their experience, expertise, and their social status. The case of *Sanctuary Doctoring* demonstrates how advocacy can happen on an individual level, by engaging in conversations about immigrants' legal status, stimulating safe environments and understanding the fear and distrust immigrants might feel in the contexts of health care. Likewise, the case of *Profamilia-Colombia* shows how physicians can mobilize in order to provide essential care for undocumented immigrants and do it in a way that is sensitive to their needs and the obstacles they face. Moreover, the case of *Physicians for Human Rights* provides an example of activism and collective advocacy actions. By promoting mobilization, calls to action and petitions for decision makers, PHR uses its medical expertise to point out injustices that affect the health of immigrants and encourage the removal of unfair policies. Finally, these cases show how being involved in health-related research, documenting and sharing the health disparities physicians

witness in their practice can be a way of advocating for undocumented immigrants. Making health injustices visible promotes a conversation in order to address this situation.

5.0 Conclusion

In this text, I have defended physicians' advocacy for the health of undocumented immigrants. Using the cases of the United States and Colombia, I have analyzed the health situation of undocumented immigrants, which is characterized by the multiple barriers of access to health care that leaves many of them with limited access or without any medical protection. I analyzed different elements of what can be considered health care access, including insurance coverage, the actual admission to health services, timeliness and the workforce capacity and appropriateness to provide the best care. Undocumented immigrants face multiple barriers in these four elements as even when they get to obtain services, they face attitudes of stigma, xenophobia and discrimination, fear towards revealing their medical and personal information and lack of continuity in their medical treatments. Furthermore, I have explained how immigration policies such as family separation and massive detention are causing concrete and long-term physician and mental health consequences for undocumented immigrants, especially in children and the most vulnerable ones.

In the United States, the anti-immigration narrative and policies have created an atmosphere of fear and mistrust, which directly impacts the health of undocumented immigrants. In Colombia, even if authorities have guaranteed the most fundamental rights of undocumented immigrants, including basic health care under urgency situations, there are many implementation barriers and undocumented immigrants' health rights are denied on a daily basis. Even if immigration measures and policies are different in both countries, undocumented immigrants are embedded in a health injustice, which is manifested in lack of primary prevention measures, worse health outcomes, high mortality rates, late disease discovery and different mental health problems,

including higher rates of suicide and trauma related signs, among others. This situation has become structural as it is grounded in certain laws, policies and institutional practices and has been socially accepted. These laws and practices have been motivated by xenophobic attitudes and racial biases.

Having explained the characteristics of this structural health injustice, this work has explained how advocacy actions can address and challenge this situation. Physicians' advocacy can be understood as a combination of targeted actions for change. Activism can be undertaken on behalf of individual patients or it can consist in actions to promote structural changes in laws and policies that affect the health of undocumented immigrants. Throughout this text, I showed different examples of the ways in which physicians can participate in advocacy to promote the health of undocumented immigrants, including: participating in public policy debates; documenting and evidencing how certain policies are affecting the health of this population; writing letters and policy papers that are based on scientific and medical evidence in order to tackle unfair policies or show how a certain action can potentially improve immigrants' health outcomes; promoting individual patient's rights empowerment, which can include the provision of information, the connection with advocacy groups, among others. These actions might involve individual actions from physicians, but can also be made in an institutional context or as part of a professional academy or professional organization.

Understanding what constitutes physicians' advocacy, this text provided two main reasons to defend advocacy for the health of undocumented immigrants. First, advocacy actions are consistent with the traditional goals of medicine and their current reinterpretation. Advocating for the health of undocumented immigrants is connected to the prevention of disease and the promotion of health; contributes to reducing pain and suffering; can be a manifestation of care in the individual and collective dimensions; and can avoid premature death and promotes dignified

and peaceful deaths. In this same line, professional organizations have linked advocacy for the health of populations and health justice as a professional duty of physicians under contemporary circumstances. In relation to health justice, this thesis explained why advocacy can be a way in which physicians promote the principle of justice in their profession. Specifically, by advocating for the health of immigrants, physicians are contributing to challenge and tackle the persisting structural health injustice this population faces and are recognizing the role that their profession has historically played in the harm and discrimination against this population. Thus, advocacy can be an effective example of restorative justice and contribute to restore the trust that immigrants have lost in the medical profession.

Second, physicians' historical privilege, social status, specialized knowledge and elevated social perception put them in a unique position to advocate where they have more access to decision makers and their actions can have a bigger social and political impact. Also, physicians' unique access to undocumented immigrants' health situation helps them evidence and document how people's health and lives are directly impacted by social injustices. Thus, advocacy is an effective way in which physicians can use and take advantage of their unique position in society. Lastly, this thesis addressed Thomas Huddle's arguments against physicians' advocacy and maintained that advocacy should not be considered a threat to the doctor and patient relationship, but an activity that even make this relationship stronger.

Finally, in order to show successful and ongoing examples of physicians and physician organizations advocating for the health of undocumented immigrants, I analyzed the cases of Physicians for Human Rights, Sanctuary Doctoring and the case of Profamilia-Colombia. With these examples, this work demonstrated that physicians' advocacy can be grounded in their own experience and expertise and can successfully impact the health of immigrants.

Overall, this thesis has made visible a persisting health injustice against undocumented immigrants in two countries. This health injustice should not only be studied and documented, but should be actively confronted. Advocacy is an effective way in which physicians can successfully contribute to change the realities of the communities they serve. Advocacy should not be understood as something that is outside the professional and ethical scope of medicine. On the contrary, advocacy actions are inevitably tied to physicians' professional duties and to the legitimate goals of the profession. This, in a contemporary context where physicians are even more aware of the ways in which unjust policies affect the health outcomes of the communities, and of how rarely outcomes change if the root causes of bad health don't change. Therefore, advocacy for the health of undocumented immigrants should be understood as an effective way in which physicians can respond to their unique position in society, their privileges and as something that can develop their skills as professionals. Then, documenting, speaking up, opposing unfair policies and promoting undocumented immigrants' health should be in physicians' ethical agenda.

Bibliography

- Abbot, Brianna. "Medical Schools Are Pushed to Train Doctors for Climate Change". *The Wall Street Journal*. August 7, 2007. <https://www.wsj.com/articles/medical-schools-are-pushed-to-train-doctors-for-climate-change-11565170205> mod=article inline
- ABIM Foundation, ACP-ASIM Foundation and European Federation of Internal Medicine. "Medical professionalism in the new millennium: A physician charter". *Ann Intern Med*. 136 (2002): 243–246, DOI:[10.7326/0003-4819-136-3-200202050-00012](https://doi.org/10.7326/0003-4819-136-3-200202050-00012)
- Acevedo, Natalia. "The medical discourse and the sterilization of people with disabilities in the United States, Canada and Colombia: From eugenics to the present". LLM dissertation, McGill University, 2015.
- Agency for Healthcare Research and Quality. "Chartbook on Access to Health Care". Accessed 20 April, 2021. <https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements.htm>
- American College of Emergency Physicians. "EMTALA fact sheet". Accessed 29 March, 2021. <https://www.acep.org/life-as-a-physician/ethics--legal/emtala/emtala-fact-sheet/>
- American Medical Association. "Declaration of Professional Responsibility". December 4, 2001. <https://www.ama-assn.org/delivering-care/public-health/ama-declaration-professional-responsibility#:~:text=We%2C%20the%20members%20of%20the,and%20compassion%20and%20without%20prejudice.>
- American Medical Association. "When water is unsafe, physicians must take up public health roles". Public Health. October 17, 2017, <https://www.ama-assn.org/delivering-care/public-health/when-water-unsafe-physicians-must-take-public-health-roles>
- American Academy of Pediatrics. "Policy Statement. Providing Care for Immigrant, Migrant, and Border Children". *PEDIATRICS*, 131, no 6, (2013): e2028- e2034.
- American Immigration Council, American Immigration Lawyers Association, Catholic Legal Immigration Network, Inc., et al. "Administrative complaint filed to Megan Mack, DHS Officer for Civil Rights and Liberties, and John Roth, DHS Inspector Gen." July 30, 2015. [https://www.aila.org/advo-media/pressreleases/2015/deplorable-medical-treatment-at-fam-detention-ctrs/public-version-of-complaint-to-crcl.](https://www.aila.org/advo-media/pressreleases/2015/deplorable-medical-treatment-at-fam-detention-ctrs/public-version-of-complaint-to-crcl)

- American Immigration Council, American Immigration Lawyers Association and the Catholic Legal Immigration Network “Letter to Sec. Kirstjen Nielsen Regarding the Detention of Infants”. February 2019.
https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_urges_immediate_release_of_infants_from_immigration_detention.pdf
- Aptekar, Sofya. “Doctors as migration brokers in the mandatory medical screenings of immigrants to the United States”. *Journal of Ethnic and Migration Studies* (June, 2019): 1-19, <https://doi.org/10.1080/1369183X.2018.1494545>
- Arenas, Natalia. “For Venezuelans, pregnancy is a crossroads”. *Cero Setenta*. December, 2019. <https://cerosetenta.uniandes.edu.co/para-las-venezolanas-el-embarazo-es-una-encrucijada/>
- Banack, Jeannine. “Do Medical Professionalism and Medical Education Involve Commitments to Political Advocacy?” *Acad Med*, Letters to the Editor 86 no 9 (September 2011):1064-1065.
- Battistessa, Diego. “Silent massacre: dead Venezuelans abroad”. *El País*. September 3, 2019. https://elpais.com/elpais/2019/09/02/planeta_futuro/1567434636_760205.html
- Benfer, Emily A. “Health justice: A framework (and call to action) for the elimination of health inequality and social injustice”. *Am. U.L Rev.* 65 no 275 (2015): 275-351.
- Betts, Alexander. *Survival Migration: Failed Governance and the Crisis of Displacement*. Ithaca: Cornell University Press: 2013.
- Berlinger, Nancy and Raghavan, Rajeev. “The Ethics of Advocacy for Un- documented Patients.” *Hastings Center Report* 43, no. 1 (2013): 14-17, DOI: [10.1002/hast.126](https://doi.org/10.1002/hast.126)
- Cardona, Andres Octavio. “What are the areas in which Venezuelans who migrate to Colombia work the most?”. *La Republica*. February, 2019. <https://www.larepublica.co/consumo/cuales-son-las-areas-en-las-que-mas-trabajan-los-venezolanos-que-migran-a-colombia-2826030>.
- Carrizosa Moog, Jaime. “Eugenesia y discriminación en Colombia: el papel de la medicina y la psiquiatría en la política inmigratoria a principios del siglo XX”. *rev colomb psiquiatr* 43 no 1 (2014): 58-63.
- CDC. “Health of Hispanic or Latino Population”. Accessed August 3, 2020. <https://www.cdc.gov/nchs/fastats/hispanic-health.htm>

- Chaves-González, Diego and Echevarria-Estrada, Carlos. “Venezuelan Migrants and Refugees in Latin America and the Caribbean. A Regional Profile”. Migration Policy Institute. August, 2020.
- Cheng YJ, Kanaya AM, Araneta MRG, et al. “Prevalence of diabetes by race and ethnicity in the United States, 2011-2016.” *JAMA* 322 (2019): 2389-2398, DOI: [10.1001/jama.2019.19365](https://doi.org/10.1001/jama.2019.19365)
- Collins, Joshua. “Why you don’t want to be a Venezuelan woman right now”. *The New Humanitarian*. 27 September, 2019. <https://www.thenewhumanitarian.org/news-feature/2019/09/17/Venezuela-femicide-maternal-mortality-rates-rising>
- Congress of Colombia. Statutory Act 1751 de 2015.
- Congress of Colombia. *Act 114 about Immigration and agricultural colonies*.1922.
- Constitutional Court of Colombia, ruling C-834 of 2007, T-314 of 2016, T-705 of 2017, SU-677 of 2017, T-210 of 2018, T-348 of 2018, T-197 of 2019, T-025 of 2019.
- Coordination Platform for Refugees and Migrant Response. “Plan for Refugees and Migrants from Venezuela, January -December 2019”. January-December 2019.
- CWLA, “Judge blocks public charge restrictions due to the pandemic”. July 29, 2020. <https://www.cwla.org/judge-blocks-public-charge-restrictions-due-to-pandemic/>
- Dang, Bich N., Giordan, Thomas P. et al. “Sociocultural and Structural Barriers to Care Among Undocumented Latino Immigrants with HIV Infection”. *J Immigrant Minority Health* 14 (2012):124–131, DOI: [10.1007/s10903-011-9542-x](https://doi.org/10.1007/s10903-011-9542-x)
- Dejusticia. “Citizen intervention in the process T7.071.275”. March 29 of 2019.
- Diaz, Chanelle. “The real border crisis: medical neglect of migrants in detention centers”. *Stat News*, January 10, 2019. <https://www.statnews.com/2019/01/10/medical-neglect-migrants-detention/>
- Dickerson, Caitlin, Freed, Seth and Jordan, Miriam. “Immigrants Say They Were Pressured into Unneeded Surgeries”. *The New York Times*. September 29 of 2020. <https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html>
- Dobson, Sarah, Stéphane, Voyer and Regehr, Glenn. “Perspective: Agency and Activism: Rethinking Health Advocacy in the Medical Profession.” *Academic Medicine*, 87, no. 9 (September 2012): 1161-1164, DOI: [10.1097/ACM.0b013e3182621c25](https://doi.org/10.1097/ACM.0b013e3182621c25)

- Dolgin, Janet L. and Dieterich, Katherine R. “When Others Get Too Close: Immigrants, Class, and the Health Care Debate”. *Cornell J. L. & Pub. Pol’y* 19 (2010): 283-334.
- Earnest, Mark A, Wong, Shale and Federico, Steven. “Perspective: Physician advocacy: what is it and how do we do it?” *Acad Med*, 85 no 1 (Jan 2010): 63-67, DOI: [10.1097/ACM.0b013e3181c40d40](https://doi.org/10.1097/ACM.0b013e3181c40d40)
- Edwards, Ashley. “Hispanic poverty rate hit in all time low in 2017”. United States Census Bureau. February 27, 2019. <https://www.census.gov/library/stories/2019/02/hispanic-poverty-rate-hit-an-all-time-low-in-2017.html>
- Eisenman, David P, Gelberg, Lillian, Liu, Honghu and Shapiro, Martin F. “Mental health and health-related quality of life among adult Latino primary care patients living in the United States with previous exposure to political violence.” *JAMA* 290 no 5 (Aug 2003): 627-34, DOI: [10.1001/jama.290.5.627](https://doi.org/10.1001/jama.290.5.627)
- Equivalencias en Acción. *Women on the edge 2019: Women’s rights in the face of the complex humanitarian emergency in Venezuela*. Caracas: Amnesty International. May, 2019.
- Fabi, Rachel and Saloner, Brendan. “Covering Undocumented Immigrants — State Innovation in California.” *Engl j med* 375 no 20 (Nov 2016): 1913-1915, DOI: [10.1056/NEJMp1609468](https://doi.org/10.1056/NEJMp1609468).
- Fabi, Rachel. “Why Physicians Should Advocate for Undocumented Immigrants’ Unimpeded Access to Prenatal Care.” *AMA Journal of Ethic* 21 no 1 (January 2019): E93-99, DOI: [10.1001/amajethics.2019.93](https://doi.org/10.1001/amajethics.2019.93).
- Fabi, Rachel. “Mandatory collection of DNA of immigrants in US detention centers”. World Bioethics Congress. June 2020.
- Fabi, Rachel. “Public Health in the Context of Migration: Ethics Issues Related to Immigrants and Refugees”. In Mastroianni, Anna C, Kahn, Jeffrey P. and Kass, Nancy E. *The Oxford Handbook of Public Health Ethics*. Oxford University Press, 2018.
- Figueroa, Jose. “The Trump administration’s ‘public charge’ rule and Covid-19: bad policy at the worst time”. *State News*. August 21, 2020. <https://www.statnews.com/2020/08/21/the-trump-administrations-public-charge-rule-and-covid-19-bad-policy-at-the-worst-time/>
- Foreign Ministry of Colombia. “Historical background and causes of migration”. Accessed 20 April, 2021. <https://www.cancilleria.gov.co/colombia/migracion/historia>
- Freeman, Josh. “Physician advocacy, activism and politics”. *Medicine and Social Justice*. October 13, 2012. <https://pnhp.org/2012/10/15/physician-advocacy-activism-and-politics/>

- “From cutting hair to turning tricks. Venezuelans sell sex in Colombia to survive”. *The Economist*. June, 2017. <https://www.economist.com/the-americas/2017/07/20/venezuelans-sell-sex-in-colombia-to-survive>
- García, Jacqueline and Gaglianone, Virginia. “Sanctuary clinics offer respite for undocumented residents amid immigration raids.” Center for Health Journalism. September 19 of 2019, <https://centerforhealthjournalism.org/sanctuary-clinics-offer-respite-undocumented-residents-amid-immigration-raids>
- Gelatt, Julia and Zong, Jie. “Settling In: A Profile of the Unauthorized Immigrant Population in the United States”, Migration Policy Institute. November, 2018. <https://www.migrationpolicy.org/research/profile-unauthorized-immigrant-population-united-states>
- GLOBSEC, “Venezuelan Migration A Growing Concern for Colombia”. March, 2018. <https://www.globsec.org/2018/03/20/venezuelan-migration-concern-colombia/>
- Goldman, Kate. “No Masks, Disinfectant or Soap. This Is Detention Amid a Pandemic.” *New York Times*. April 2, 2020. <https://www.nytimes.com/2020/04/02/opinion/coronavirus-ice-immigration-detention.html?fbclid=IwAR0RVcsUDDaiX7QUFRfhq0W0Ek1rVgMyxdkqpV41Qtz9bP9Ar9Dc7n8bZOo>
- Hacker, Karen, Chu, Jocelyn, Arsenault, Lisa, et al. “Provider’s Perspectives on the Impact of Immigration and Customs Enforcement (ICE) Activity on Immigrant Health.” *J Health Care Poor Underserved* 23 no 2 (May, 2012): 651-665, DOI: [10.1353/hpu.2012.0052](https://doi.org/10.1353/hpu.2012.0052).
- Hacker, Karen, Anies, Maria, Folb, Barbara L, et al. “Barriers to health care for undocumented immigrants: a literature review”. *Risk Management and Healthcare Policy*, 8 (Oct 2015): 175–183, DOI: [10.2147/RMHP.S70173](https://doi.org/10.2147/RMHP.S70173).
- Hacker, Karen, Chu J, Leung C, et al. “The impact of Immigration and Customs Enforcement on immigrant health: perceptions of immigrants in Everett, Massachusetts, USA.” *Soc Sci Med*. 73 no 4 (2011): 586-594, DOI: [10.1016/j.socscimed.2011.06.007](https://doi.org/10.1016/j.socscimed.2011.06.007)
- Healthy People 2020. “Access to Health Services”. Accessed 20 April, 2021. <http://www.healthypeople.gov/2020/topics-objectives/topic/Access-to-Health-Services>
- Henry J. Kaiser Family Foundation. “Where are states today? Medicaid and CHIP eligibility levels for children, pregnant women, and adults”. accessed June 8, 2020. <https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/>.

- Harbut, Rachel F. “AMA Policies and Code of Medical Ethics’ Opinions Related to Health Care for Patients Who Are Immigrants, Refugees, or Asylees”. *AMA Journal of Ethics*, 21, no 1 (January 2019): E73-77.
- Hendow, Maegan, “When Disaster Strikes: Responding to Migrants Caught in Crises”, Migration Policy Institute, September 2018.
- Hernandez, Tanya. *Racial subordination in Latin America. The Role of the State, Customary Law and the New Civil Rights Response*. New York: Cambridge University Press, 2013.
- Hubinette MM, Ajjawi R, Dharamsi S. “Family physician preceptors' conceptualizations of health advocacy: implications for medical education” *Acad Med*. 89 no 11 (Nov 2014):1502-9, DOI: [10.1097/ACM.0000000000000479](https://doi.org/10.1097/ACM.0000000000000479).
- Huddle, Thomas S. “Perspective: Medical professionalism and medical education should not involve commitments to political advocacy.” *Acad Med*. 86 no 3 (March 2011):378–383, DOI: [10.1097/ACM.0b013e3182086efc](https://doi.org/10.1097/ACM.0b013e3182086efc)
- Human Rights Watch. “Venezuela: Numbers Highlight Health Crisis Disease Outbreaks; Lives at Risk”. November 15, 2018. <https://www.hrw.org/news/2018/11/15/venezuela-numbers-highlight-health-crisis>
- Institute of Medicine, et al. *Access to Health Care in America*, edited by Michael Millman. Washington, DC: National Academy Press, 1993.
- “Introduction” in “The Collapse of Venezuela. The Failed Policies That Drove the Country to Disaster”, *Foreign Affairs*. November 12, 2019. <https://www.foreignaffairs.com/articles/venezuela/2019-11-12/introduction>
- Immigrant Legal Center Resource. “Public charge. Outreach Toolkit”. Accessed 15 July, 2020. https://www.ilrc.org/sites/default/files/resources/2020.09_ilrc_public_charge-what_community_needs_to_know_0.pdf
- International Labour Organization. “Informal job”. Accessed June 30, 2020. <https://www.oitcinterfor.org/en/taxonomy/term/3366>
- International Organization for Migration (IOM), “Key migration terms”. Accessed May 1, 2020. <https://www.iom.int/key-migration-terms>
- International Federation Gynecology and Obstetrics). “Statement on Health of Refugees and Migrants in Colombia”. June 19, 2019. <https://www.figo.org/es/declaracion-sobre-la-salud-de-las-refugiadas-y-las-inmigrantes-en-colombia>

- Israelowich, Ido. “Physicians as Figures of Authority in the Roman Courts”, *Historia: Zeitschrift für Alte Geschichte*, Bd. 63, H. 4 (2014): 445-462.
- Iten, Elizabeth, Jacobs, Elizabeth, et al. “Undocumented Immigration Status and Diabetes Care Among Mexican Immigrants In Two Immigration “Sanctuary” Areas.”, *J Immigrant Minority Health* 16 (2014):229–238.
- Jiménez Lopez, Miguel. “Primera conferencia”, In Luis López de Mesa et al. (editor), *Los problemas de la raza en Colombia*. Bogota: El Espectador, 1920.
- Klugman, Craig. “Immigrant DNA Collection: Fighting Crime or Moral Panic”. The Hastings Center. October 29, 2019. <https://www.thehastingscenter.org/immigrant-dna-collection-fighting-crime-or-moral-panic/>
- Kim, Jahum, Nicodimos, Semret, et al. “Comparing Mental Health of US Children of Immigrants and Non-Immigrants in 4 Racial/Ethnic Groups.” *Journal of School Health*, 88 no 2 (February 2018): 167-175, DOI: [10.1111/josh.12586](https://doi.org/10.1111/josh.12586).
- Kraut, Alan M. “Bodies from Abroad: Immigration, Health, and Disease”. In Reed Ueda (editor), *A companion to American immigration*. Malden: Blackwell Publishing, 2006.
- Kretz, Nathaniel, Diaz, Chanelle and Pereira, Xavier. “Immigration detention is a public health hazard”. *New York Daily News*, May 2020. <https://www.nydailynews.com/opinion/ny-oped-immigration-detention-public-health-hazard-20200507-meszox56jhlplaxnj6loujci-story.html>
- Kuczewski, Mark, Mejias-Beck, Johana and Blair, Amy. “Good Sanctuary Doctoring for Undocumented Patients”. *AMA Journal of Ethics* 21 no 1 (January, 2019): E78-85. <https://journalofethics.ama-assn.org/article/good-sanctuary-doctoring-undocumented-patients/2019-01>
- Kuczewski, Mark, Lantos, John D., Patel, Zarna. “Advocating for the DREAM Act: Why Pediatricians Should Care and What They Can Do.” *Pediatrics*. 141 no 1 (2018), DOI: <https://doi.org/10.1542/peds.2017-3314>.
- Kuczewski, Mark. “Clinical Ethicists Awakened: Addressing Two Generations of Clinical Ethics Issues Involving Undocumented Patients”. *The American Journal of Bioethics*, 19 no 4 (2019): 51-57, DOI: <https://doi.org/10.1080/15265161.2019.1572812>
- Kuczewski, Mark. “The Really New Jim Crow: Why Bioethicists Must Ally with Undocumented Immigrants”. *The American Journal of Bioethics*, 16 no 4 (April, 2016): 21-24, DOI: [10.1080/15265161.2016.1145294](https://doi.org/10.1080/15265161.2016.1145294)

- Kuczewski, Mark. "Can Medical Repatriation Be Ethical? Establishing Best Practices". *The American Journal of Bioethics*, 12 no 9 (Aug, 2012): 1–5, DOI: <https://doi.org/10.1080/15265161.2012.692433>
- Kullgren, Jeffrey T. "Restrictions on Undocumented Immigrants' Access to Health Services: The Public Health Implications of Welfare Reform." *American Journal of Public Health*, 93 no 10 (October 2003): 1630-1633, DOI: [10.2105/ajph.93.10.1630](https://doi.org/10.2105/ajph.93.10.1630)
- "Labour reality of Venezuelans in Colombia". *El Tiempo*. 26 February, 2020. <https://www.eltiempo.com/economia/sectores/realidad-laboral-de-venezolanos-en-colombia-466664>
- León, Ana. "Xenophobia against Venezuelans worsens amid the pandemic". *La Silla Vacía*. April 1, 2020. <https://lasillavacia.com/xenofobia-contra-venezolanos-recrudece-medio-pandemia-76074>
- Lipworth, Wendy, Miles, Miles, Pippa, Little, et al. "Doctors on status and respect: A qualitative study." *J Bioethical Inquiry*, 10 no 2(2013): 205-217, DOI: [10.1007/s11673-013-9430-2](https://doi.org/10.1007/s11673-013-9430-2).
- Luft, LeeAnne M. "The essential role of physician as advocate: how and why we pass it on". *Canadian Medical Education Journal*, 8 no 3 (June 2017): e109–e116.
- Maeso, Marta. "14 examples of how the crisis in Venezuela affect women the most". *El País*, August, 2019. https://elpais.com/elpais/2019/08/07/planeta_futuro/1565169579_350421.html.
- Martínez, Abel Fernando. "Trópico y raza. Miguel Jiménez López y la inmigración japonesa en Colombia, 1920-1929". *Historia y Sociedad*, 32 (Jan-2017): 103-138.
- Mejias-Beck, Johana, Kuczewski, Mark and Blair, Amy. "Treating Fear: Sanctuary Doctoring". Toolkit, June 2018. <https://hsd.luc.edu/media/healthsciencesdivision/bioethics/documents/Sanctuary-Doctoring-presentation-June2018.pdf>
- Mercy Corps, "Quick facts: Venezuela's humanitarian crisis". Accessed August 13, 2019. <https://www.mercycorps.org/articles/venezuela-crisis-quick-facts>
- Messina, Anthony M. and Lahav, Gallya (editors). *The Migration Reader: Exploring Politics and Policies*. Boulder: Lynne Rienner, 2006.
- Millum, Joseph and Emanuel, Ezekiel J. *Global Justice and Bioethics*. Oxford: Oxford Scholarship:2015.

- Minister of Health and Social Protection of Colombia. “Health sector response to the migratory phenomenon”. 2019.
<https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COM/plan-respuesta-salud-migrantes.pdf>
- Minister of Health and Social Inclusion of Colombia. Circular 25 of July 31 of 2017.
<https://www.minsalud.gov.co/sites/rid/Lists/BibliotecaDigital/RIDE/DE/COM/plan-respuesta-salud-migrantes.pdf>
- Minister of Health and Social Protection of Colombia. Resolution 5269 of December 22, 2017, Article 8, number 5.
- Molina, Natalia. *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939*. Berkeley: University of California Press, 2006.
- Moloney, Anastasia. “As Venezuela's healthcare collapses, pregnant women, girls bear brunt of crisis”, Reuters. July 2019. <https://www.reuters.com/article/us-venezuela-health-women/as-venezuelas-healthcare-collapses-pregnant-women-girls-bear-brunt-of-crisis-idUSKCN1U32AS>.
- Monsignor Oscar A. Romero Clinic, “Who we are”. Accessed November 19, 2020.
<https://clinaromero.com/>
- Montoya, Camilo. “15-year-old girl who spent her life in the U.S. facing deportation after hospital arrest”. *CBS News*. September 25, 2020. <https://www.cbsnews.com/news/15-year-old-girl-who-spent-her-life-in-the-u-s-facing-deportation-after-hospital>
- Narea, Nicole. “A federal judge blocked Trump’s rule creating a wealth test of immigrants”. *Vox*. July, 30, 2020. <https://www.vox.com/policy-and-politics/2019/10/11/20899253/trump-public-charge-rule-immigrants-welfare-benefits>
- Noguera, Carlos Ernesto. *Medicina y Política. Discurso médico y prácticas higiénicas durante la primera mitad del siglo XX en Colombia*. Medellín: Fondo Editorial Universidad EAFIT, 2003.
- NYC Health + Hospitals, “Seek care without fear”. accessed November 15, 2020.
<https://www.nychealthandhospitals.org/immigrant/>
- NYC Health + Hospitals, “Open Letter to Immigrant New Yorkers”. December 2016- Reissued April 2019.
https://hhinternet.blob.core.windows.net/uploads/2019/04/immigrantCampaign_LetterFlyer.pdf

- Ordaz, Jessica. "Migrant detention centers have a long history of medical neglect and abuse". *The Washington Post*. September 18, 2020. <https://www.washingtonpost.com/outlook/2020/09/18/migrant-detention-centers-have-long-history-medical-neglect-abuse/>
- Page, Kathleen R. and Polk, Sarah. "Chilling Effect? Post-Election Health Care Use by Undocumented and Mixed-Status Families." *N engl j med* 376 no 12 (March 2017): e20(1)- e20(3), DOI: [10.1056/NEJMp1700829](https://doi.org/10.1056/NEJMp1700829).
- Page, Kathleen and Venkataramani, Maya et al. "Undocumented U.S. Immigrants and Covid-19." *N engl j med* 382, no 21(2020), E621, DOI: [10.1056/NEJMp2005953](https://doi.org/10.1056/NEJMp2005953)
- Palacio, Claudia. "Dejen de parir". *El Tiempo*. June, 2019. <https://www.eltiempo.com/opinion/columnistas/claudia-palacios/paren-de-parir-columna-de-claudia-isabel-palacios-giraldo-374742>.
- "Pendular Migration, another one of the variables in the Colombian-Venezuelan migration". *Sectorial*. May 13, 2020. <https://www.sectorial.co/articulos-especiales/item/320785-migraci%C3%B3n-pendular,-otra-de-las-variables-en-la-relaci%C3%B3n-colombia-venezuela>
- Pennachio, Dorothy L. "What Would You Do? In This Border-Town Dilemma". *Medical Economics*. June 18, 2004. [http://medicaleconomics.modernmedicine.com/memag/nfectious+Disease/What-would-you-dobrln-this-border-town-dilemma/Article Standard/Article/detail/108972](http://medicaleconomics.modernmedicine.com/memag/nfectious+Disease/What-would-you-dobrln-this-border-town-dilemma/Article%20Standard/Article/detail/108972).
- Physicians for Human Rights, "About". Accessed November 16, 2020. <https://phr.org/about/>
- Physicians for Human Rights. "Global conflicts, civil wars, and injustice have driven immigration to an all-time high since 1990. Seeking asylum from persecution is a human right". Accessed November 16, 2020. <https://phr.org/issues/asylum-and-persecution/>
- Physicians for Human Rights. "Guides and Protocols for Clinicians". Asylum Network Resources. Accessed November 17, 2020. <https://phr.org/issues/asylum-and-persecution/asylum-network-resources-linked/>
- Physicians for Human Rights. "Health Harms Experienced by Pregnant Women in U.S. Immigration Custody". PHR Fact Sheet. 2019.
- Physicians for Human Rights, "Letter to Sec. Kirstjen Nielsen Regarding the Detention of Infants", February 2019. https://www.americanimmigrationcouncil.org/sites/default/files/general_litigation/complaint_urges_immediate_release_of_infants_from_immigration_detention.pdf

- Physicians for Human Rights, “The Impact of Immigration Detention on Migrant Mental Health”, *PHR Issue Brief*, Oct 2018.
- Physicians for Human Rights. “There Is No One Here to Protect You. Trauma among children Fleering Violence in Central America”. *PHR Report*. June, 2019.
- Physicians for Human Rights. “Our founders believed that health professionals are uniquely positioned to prevent serious human rights abuses”. Accessed November 16, 2020. <https://phr.org/about/history/>
- Physicians for Human Rights, “PHR Asylum Program”. Accessed November 16, 2020. <https://phr.org/issues/asylum-and-persecution/phr-asylum-program/>
- Physicians for Human Rights, “You Will Never See Your Child Again. The Persistent Psychological Effects of Family Separation”. *PHR Report*. February 2020.
- Physicians for Human Rights, “We use our authoritative voice to protect human rights and end impunity for perpetrators”. Accessed November 16, 2020. <https://phr.org/our-work/how-we-work/we-advocate/>
- Physicians for Human Rights. “We enable front line human rights defenders to expose violations and hold perpetrators accountable”. Accessed November 17, 2020. <https://phr.org/our-work/how-we-work/we-empower/> .
- Plazas, Natalia. “More than 90,000 Venezuelans have returned to Venezuela from Colombia during the pandemic”. *France 24*. July 22, 2020. <https://www.france24.com/es/20200721-venezuela-migrantes-colombia-retorno-coronavirus>
- Pierce, Sarah and Bolter, Jessica. “Dismantling and Reconstructing the U.S. Immigration System. A Catalog of Changes under the Trump Presidency”. Migration Policy Institute. July 2020.
- Portwood, Derek and Fielding, Alan. “Privilege and professions.” *Sociological Review* 29 no. 4 (1981): 749-774.
- Pompa, Cynthia. “Immigrant Kids Keep Dying in CBP Detention Centers, and DHS Won’t Take Accountability”. American Civil Liberties Union (ACLU). June 24, 2019. <https://www.aclu.org/blog/immigrants-rights/immigrants-rights-and-detention/immigrant-kids-keep-dying-cbp-detention>
- Powers, Madison, et al. *Social Justice: The Moral Foundations of Public Health and Health Policy*. Oxford: University Press, 2008.
- Profamilia, “about”. Accessed November 17, 2020. <https://profamilia.org.co/somos/>

- Profamilia, *Assessment of unmet needs in sexual health and reproductive health of the migrant population in four cities of the Colombian-Venezuelan border: Arauca, Cúcuta, Riohacha and Valledupar*. Bogota: IPPF, 2019. <https://profamilia.org.co/wp-content/uploads/2019/05/Evaluation-of-the-sexual-and-reproductive-health-needs.pdf>
- Profamilia and the Office of the United States for Disaster Assistance Abroad (OFDA-USAID), *Health inequalities of the migrant population and a Venezuelan refugee in Colombia. How to improve local response within the humanitarian emergency?* Bogota: Profamilia, 2020.
- Proyecto Migración Venezuela, “Colombia will have a single regional vaccination card for Venezuelan immigrants”. 27 of August, 2019. <https://migravenezuela.com/web/articulo/tarjeta-de-vacunacion-para-migrantes-venezolanos/1441>
- Rafei, Leila. “Family Separation, Two Years After MS.L”. American Civil Liberties Union ACLU. February 26, 2020. <https://www.aclu.org/news/immigrants-rights/family-separation-two-years-after-ms-l/>
- Reed MM, Westfall JM, Bublit C, Battaglia C and Fickenscher A. “Birth outcomes in Colorado’s undocumented immigrant population”. *BMC Public Health* 5 no 1 (2005):100.
- Rose, Joel. “Growing Calls To Close Immigration Courts And Release Detainees As Virus Spreads”. NPR. March 21 2020. <https://www.npr.org/2020/03/21/819275605/growing-calls-to-close-immigration-courts-and-release-detainees-as-virus-spreads>
- Rossi, Justin. “The Challenge of Physician Civic Engagement: Promoting Health While Preserving Public Trust.” *AMA Journal of Ethics*,16, no 1(2014): 896-900.
- Saadi, Altaf, Ahmed, Sameer and Katz, Mitchell. “Making a Case for Sanctuary Hospitals”. *JAMA* 318, no 21 (December,2017): 2079-2080, DOI: [10.1001/jama.2017.15714](https://doi.org/10.1001/jama.2017.15714)
- Saadi, Altaf and McKee, Martin. “Hospitals as places of sanctuary”, *BMJ* 361(2018).
- Samra, Shamsher, Taira, Breena R., Pinheiro, Erika, et al. “Undocumented Patients in the Emergency Department: Challenges and Opportunities.” *Western Journal of Emergency Medicine*, 20, no. 5 (2019): 791-798, DOI: [10.5811/westjem.2019.7.41489](https://doi.org/10.5811/westjem.2019.7.41489)
- Schaub, Michael. “‘Xenophobia’ is the word of the year for 2016, says Dictionary.com”. *Los Angeles Times*. November 28, 2016. <https://www.latimes.com/books/la-et-jc-xenophobia-word-of-the-year-20161128-story.html>

- Schickedanz, Adam, Neuhauser, Katherine, et al, "Do Medical Professionalism and Medical Education Involve Commitments to Political Advocacy?". *Academic Medicine*, Letters to the Editor, 86 no 9 (September, 2011): 1064-1065.
- Selee, Andrew and Bolter, Jessica. "An Uneven Welcome. Latin American and Caribbean Responses to Venezuelan and Nicaraguan Migration". Migration Policy Institute. February 2020.
- Singh, Maanvi and Koran, Mario. "The virus doesn't discriminate but governments do: Latinos disproportionately hit by coronavirus". *The Guardian*. April 18, 2020. <https://www.theguardian.com/us-news/2020/apr/18/the-virus-doesnt-discriminate-but-governments-do-latinos-disproportionately-hit-by-coronavirus>
- Sommers, Benjamin D., Allen, Heidi, Bhanja, Aditi, et al. "Assessment of Perceptions of the Public Charge Rule Among Low-Income Adults in Texas". *JAMA Network Open* 3 no 7 (Jul 2020): 1-5, DOI: [10.1001/jamanetworkopen.2020](https://doi.org/10.1001/jamanetworkopen.2020)
- Sontag, Deborah, "Immigrants Facing Deportation by U.S. Hospitals". *New York Times*. August 3, 2008. <https://www.nytimes.com/2008/08/03/us/03deport.html>
- Specker Sullivan, Laura. "Trust, Risk, and Race in American Medicine." *Hastings Center Report* 50, no. 1 (February 2020): 18-26, DOI: <https://doi.org/10.1002/hast.1080>
- Squir, Vicki and Dimitriadi, Angeliki, et al, "Crossing the Mediterranean Sea by Boat: Mapping and documenting migratory journeys and experiences", University of Warwick, Hellenic Foundation for European & Foreign Policy (ELIAMEP), February 2019.
- Stanbrook, Mathew. "Gun control: a health issue for which physicians rightfully advocate". *Canadian Medical Association Journal*, 191 no 16 (2019): E434–E435, DOI: [10.1503/cmaj.190401](https://doi.org/10.1503/cmaj.190401)
- Stepan, Nancy Ley. *The Hour of Eugenics. Race, gender and nation in Latin America*. New York: Cornell University Press, 1991.
- Stoltz, Norma, Hamilton, Nora and Loucky, James. "The Sanctuary Movement and Central American Activism in Los Angeles". *LATIN AMERICAN PERSPECTIVES*, 169, 36 no. 6 (November 2009): 101-126.
- Sud, Sohil R., et al, "Do Medical Professionalism and Medical Education Involve Commitments to Political Advocacy?" *Acad Med*, Letters to the Editor 86 no 9 (September 2011): 1064-1066.

- The American Bar Association, “Impact of COVID-19 on the Immigration System”. Accessed March 2, 2021.
https://www.americanbar.org/groups/public_interest/immigration/immigration-updates/impact-of-covid-19-on-the-immigration-system/
- The Hastings Center. “The Goals of Medicine. Setting New Priorities”. *Hasting Center Report*, (November, 1996): s1-s27.
- “The drama of Venezuelans to give birth during quarantine”. *Frontera*. May 2, 2020.
<https://www.laopinion.com.co/frontera/el-drama-de-las-venezolanas-para-dar-luz-en-la-cuarentena>
- Timmermans, Stefan and Oh, Hyeyoung. “The Continued Social Transformation of the Medical Profession”. *Journal of Health and Social Behavior*, 51 (2010): S94-S106, DOI:
<https://doi.org/10.1177/0022146510383500>
- Topol, Erik. “Why Doctors Should Organize”. *The New Yorker*. August 5, 2019.
https://www.newyorker.com/culture/annals-of-inquiry/why-doctors-should-organize?utm_source=onsite-share&utm_medium=email&utm_campaign=onsite-share&utm_brand=the-new-yorker
- “Undocumented patients face unique ethical concerns with end-of-life care”, *Relias Media*. December 1, 2014. <http://www.ahcmmedia.com/articles/111455-undocumented-patients-face-unique-ethical-concerns-with-end-of-life-care>
- United Nations, “Why “Undocumented” or “irregular”?”. Accessed May 6, 2020.
https://www.unhcr.org/cy/wp-content/uploads/sites/41/2018/09/TerminologyLeaflet_EN_PICUM.pdf
- United Nations. “Convention relating to the Status of Refugees”. Adopted on 28 July, 1951. Art. 1A (2).
- “Venezuelan migrants walk back to their country on account of the Coronavirus”. *El Espectador*. April 4, 2020. https://www.elespectador.com/noticias/el-mundo/migrantes-venezolanos-caminan-de-regreso-su-pais-por-cuenta-del-coronavirus-articulo-912983?fbclid=IwAR3HYLHtdU5AsFq0hltNLv4-UvQsodfU_tgd1Mi_tHAYxKEUIH2ebZC8_dY
- “Venezuelans with transplants live in fear as medicine runs out”. *Reuters*. February 21, 2018.
<https://nypost.com/2018/02/21/venezuelans-with-transplants-live-in-fear-as-medicine-runs-out/>

- Wan, William. "Coronavirus kills far more Hispanic and Black children than White youths, CDC study finds". *The Washington Post*. September 15, 2020. https://www.washingtonpost.com/health/2020/09/15/covid-deaths-hispanic-black-children/?fbclid=IwAR2RkgYPTozSxuG0A_gHR-N7iJ_SeA39w3w1_txqyCVRy7xIygewH2iNir0
- Waitzki, Howard. "Social Medicine Then and Now: Lessons from Latin America". *American Journal of Public Health* 91 no 10 (Oct 2001): 1592-1601.
- Wicclair, Mark R. "Ethics case. Positive Claims of Conscience and Objections to Immigration Law". *AMA Journal of Ethics* 15 no 3(March 2013): 188-192.
- Wolbert, Samuel. "Universal healthcare and access for undocumented immigrants." *PITT. J. ENVTL. & PUB. HEALTH L*, 5 no 61(2011): 61-79. DOI: [10.5195/pjeph.2011.23](https://doi.org/10.5195/pjeph.2011.23)
- World Politics Review. "Corruption and violence not failed ideologies are driving Central American exodus". August 1, 2019. <https://www.worldpoliticsreview.com/articles/28086/corruption-and-violence-not-failed-ideologies-are-driving-central-america-s-exodus>
- World Politics Review, "Corruption and violence not failed ideologies are driving Central American exodus". Accessed August 1, 2019- <https://www.worldpoliticsreview.com/articles/28086/corruption-and-violence-not-failed-ideologies-are-driving-central-america-s-exodus>
- Young, Iris Marion and Nussbaum, Martha. *Responsibility for Justice*. Oxford: Oxford University Press, 2013.
- Zernova, Margarita. *Restorative Justice: Ideals and Realities*. Taylor & Francis Group, London: 2007.
- Zilber, Claire. "Ethics and the doctor–patient relationship". Brown University, https://www.brown.edu/Courses/BI_278/Other/Clerkship/Didactics/Readings/ETHICS%20AND%20THE%20DOCTOR.pdf
- Zion, Deborah. "On beginning with justice: Bioethics, advocacy and the rights of asylum seekers." *Bioethics*, Special Issue: Advocates and Activists, 33 (2019) :890–895, DOI: <https://doi.org/10.1111/bioe.12660>