Injured by the Border

Security Buildup, Migrant Bodies, and Emergency Response in Southern Arizona

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Introduction: Body on the Line

His body was bisected by the line—la línea divisora, the dividing line, is what many here call the international boundary separating Mexico from the United States. Unable to move forward or retreat, the man was stuck, trapped under the border fence on the hill about two hundred yards south of the Morey pedestrian crossing between Nogales, Sonora, and Nogales, Arizona. That late afternoon about a decade ago, a group of Mexicans managed to fold up the metal sheets—formerly used by the military as aircraft landing pads in the Vietnam War—just enough to be able to crawl onto the U.S. soil. But he was not among those who succeeded in what the law designates an “illegal entry.” Emergency responders from both sides of the border were dispatched to the scene to rescue the trapped man.¹
Temo, one of the volunteer firefighters, the bomberos, in Nogales, Sonora, said that when they arrived they found twenty-something-year-old wedged halfway through the fence. His upper body was in Arizona, but his legs—they remained in Sonora. He pleaded with his rescuers, armed with hydraulic tools, popularly known as “the jaws of life,” to pull him back into Mexico. He didn’t want to end up in the United States, where the Border Patrol was waiting to take him into custody. The bomberos tried, but without success. “We couldn’t get him out here [to Nogales, Sonora]. We had to push him over there [to Nogales, Arizona].” “Barefoot.” Apparently, when the man got stuck under the fence, he shouted at the passersby to help him out, hoping that someone would pull him back into Mexico. Instead, they stole his sneakers.

“Qué chiste!” What a joke! Temo laughed, telling me about this incident, one among many he has witnessed during his career as an emergency responder on the U.S.-Mexico border. Before joining the bomberos, Temo spent fourteen years volunteering for the Mexican Red Cross. His passion has always been rescue—confined-space rescue, high-altitude rope rescue, water rescue. He was assigned to the central station, the closest firehouse to the border. The day of our interview Temo was on twenty-four-hour shift, and our conversation kept being interrupted by the dispatch calling him on the radio.

How are the marks that security enforcement on the U.S.-Mexico border leaves on the bodies of unauthorized migrants used both as evidence of their victimhood, entitling them to medical care, and their illegality, warranting detention and deportation? This chapter looks at the injured body of the migrant as contested evidence entangled in overlapping, yet divergent regimes of power and knowledge in emergency medical care and security enforcement. Paramedics who work for local fire departments in southern Arizona are often called to help people who bear the direct consequences of increased securitization and militarization of the region: unauthorized entrants who break their legs when trying to jump over the fence or who suffer from severe dehydration and even heat stroke while crossing hazardous desert terrain in an attempt to avoid checkpoints on all northbound roads. The law requires pre-hospital medical service providers to screen, treat, and stabilize anyone who seeks emergency medical care regardless of her or his legal status. Yet, criminalization of migration and security buildup on the U.S. Southwest border have created tensions between federal, state, and local authorities and taxpaying residents regarding limited resources and uncompensated costs incurred rescuing border crossers. These disagreements have led to a redefinition of access to lifesaving treatment. Unauthorized border crossers who call 911
routinely get redirected to the Border Patrol instead of the local fire and rescue departments. Prior to receiving medical attention, they are often placed into Border Patrol custody and later deported straight from the hospital—if they are taken there in the first place.

I begin this chapter with an overview of research and scholarship on the risks and dangers that unauthorized migrants face when they try to cross the border from Mexico to the United States. The hazards have changed—they have intensified—as a direct consequence of new border security infrastructures and surveillance technologies that the Border Patrol developed and put in place along the international boundary. The U.S.-Mexico border has become the frontline in the “war on drugs” as well as what looks like a “war” on undocumented migration—in fact, from the federal agency’s standpoint and often in practice, the two are inseparable. Using data collected during ethnographic research in fire and rescue departments along the Arizona-Sonora border in 2015–16, I discuss how firefighters and paramedics navigate ethical, legal, and political directives when they are called to rescue injured border crossers. The most difficult, and controversial, part of their job becomes the ability to recognize when the scene is safe to treat the patient because it requires emergency responders to make rash distinctions between undocumented migrants, or the “good guys” who deserve help, and drug runners, or the “bad guys” who pose danger to the rescuers themselves and should not be approached until they are in the custody of the Border Patrol. Through repeated encounters with injured border crossers, emergency responders have developed skills to read migrant bodies for evidence, enabling them to make ethical decisions about safe provision of medical care in potentially violent encounters along the border.

Injuries Are Not Accidents

Many life-threatening injuries in the U.S.-Mexico border space are not accidents. Rather, they result from structural conditions created by the escalation of violence and security enforcement in the borderlands. Criminalization of immigration, which took off in the 1990s and was further radicalized by concerns with terrorism in the aftermath of September 11, 2001, led the U.S. government to designate its southwestern border with Mexico as a threat to homeland security, thereby justifying amassing law enforcement resources to protect it and waging in the borderlands what has been likened to “a low-
intensity warfare” (Dunn 1996). To deter unauthorized entry, the government has employed a combination of personnel, technology, and infrastructure, which have made crossing the border considerably more difficult.

Present border security policies are traced back to Operation Blockade / Hold the Line in El Paso, Texas, in 1993; Operation Gatekeeper in San Diego, California, in 1994; and Operation Safeguard in Nogales, Arizona, the same year. These strategies focused on fortifying urban areas that had traditionally been the most popular crossing corridors for unauthorized migrants (Nevins 2010). The Border Patrol’s strategic plan, which the agency adopted in 1994, was aimed at deterring unauthorized entry by making towns less accessible—building a taller fence that is more difficult to scale without getting seriously hurt and deploying more Border Patrol agents to watch over it. Known as “prevention-through-deterrence,” this strategy was expected to redirect migrants toward the inhospitable terrain of the Sonoran Desert, which was “less suited for crossing and more suited for enforcement” (USBP 1994, 7). There would be no need (authors of the plan thought) to install a fence all along the U.S.-Mexico border. Further from the urban areas, the harsh environment itself would serve as an effective barrier and a discouragement. It didn’t happen exactly the way the Border Patrol predicted. The difficulty of this life-threatening journey did not dissuade migrants from trying to get across. Many were effectively rerouted away from border towns, as the strategy had intended, and pushed into the desert, creating what scholars have called “the funnel effect” (Rubio-Goldsmith et al. 2006). But they were not deterred. Instead, they learned to adapt to the new circumstances and the increasingly dangerous itinerary.

In response to continuing unauthorized migration through the Sonora-Arizona border, earlier government policies were updated and expanded, first, through the Secure Border Initiative (SBI), and, most recently, by adopting the Arizona Border Surveillance Technology Plan. The most visible and substantial investments in the latest stages of border militarization have been the physical and the so-called virtual wall to separate Mexican and predominantly Mexican American communities on both sides of the international divide (Heyman 2008; McGuire 2013). The U.S. Border Patrol, operating under the Department of Homeland Security, uses advanced technologies of policing and detection, combining remotely operated infrared cameras, heat sensors, tower-mounted radars, and unmanned aerial vehicles (UAVs, such as Predator-B drones). Statistical data is often unreliable in evaluating such measures in terms of their effectiveness at deterring or intercepting drug traffick-
ing and human smuggling into the United States (Isacson, Meyer, and Davis 2013). However, it has been demonstrated that the trend of border militarization that began in the 1990s and escalated after 9/11—including the adoption of “prevention-through-deterrence” as the primary immigration enforcement strategy, the increase in the numbers of the U.S. Border Patrol agents, and the parallel multiplication of the Mexican military—have all added to the escalation of violence and resulted in a border-crossing experience that is extremely dangerous (Cornelius 2001; Rubio-Goldsmith et al. 2006; Jimenez 2009; Doty 2011; Slack and Whiteford 2011; Infante et al. 2012; De León 2015).

Stringent security policies are directly linked to the routinization of migrant deaths. According to a report prepared in 2009 by the American Civil Liberties Union (aclu), deaths of an estimated 5,607 unauthorized migrants over the last fifteen years were a predictable and inhumane outcome of border security policies (Jimenez 2009, 7–8). Migrants who are trying to cross into the United States are funneled into less policed but more geographically and environmentally difficult desert and mountain areas in Arizona. Increasingly, they have come to rely on guides linked to drug cartels, leading to robberies, kidnapping, physical abuse, and rape (Jimenez 2009, 25). Some get lost or are abandoned by smugglers, especially when they are injured or in distress. Most deaths occur due to environmental factors, primarily from exposure to extreme heat or cold (temperatures can reach over 120 degrees Fahrenheit during summer days and drop below freezing during winter nights) and dehydration, as people typically never carry enough water to sustain themselves on a multiday crossing (De León 2012). Researchers and activists who work with recovering, identifying, and repatriating migrant remains note that besides existing diseases, other common causes of death while crossing the border include blunt force injuries, train and motor vehicle accidents, gunshot wounds, natural disasters, such as fire and drowning in rivers and irrigation canals (Jimenez 2009, 24). Referring to these deaths as a result of “natural causes” or “unintended effects” of “prevention-through-deterrence” deflects official responsibility (Doty 2009).

There are specific patterns of injury and death that can be traced back to border securitization and militarization. For example, drawing on ethnographic and archaeological data from the Undocumented Migration Project in the Sonoran Desert, Jason De León (2012) has shown how material objects that migrants adopt to help them avoid being caught by border enforcement agents—black plastic water jugs, cheap sneakers, darkly colored clothes—act on people’s bodies, causing specific types of injuries. By exam-
ining “use-wear” of objects that migrants take with them across the border, he argues that border crossing is a well-structured, dangerous, and violent social process (480). Jeremy Slack and Scott Whiteford (2011) have described how migrants are made vulnerable through encounters with the Border Patrol, coyotes, bandits, and traffickers. They note that women, children, and monolingual indigenous migrants face the greatest risk. Wendy Vogt (2013) has discussed injuries experienced by Central American migrants, as their bodies become commodities in the economies of violence and humanitarian aid during their journey across Mexico. Her research in migrant shelters documents stories of mutilation when people fall off the freight trains colloquially known as La Bestia, as well as rape and assault. These occurrences are not accidents—they must be understood as the result of structural, state, and local economies of violence and inequality.

Despite the risks, many migrants make it across the border alive, but because of severe injuries caused by the journey, they are in need of emergency medical care. In addition to heat exhaustion, dehydration, and hypothermia, they suffer spinal fractures and other orthopedic injuries resulting from trying to jump the border fence, friction blisters, intestinal illness from drinking contaminated water in cattle tanks, and major traumas from human smuggling van rollovers and other transportation-related injuries. The close relationship between securitization of the border and increased number of medical emergencies treated by emergency medical services (EMS) is illustrated by the following detail: Nogales International reported that when in 2011 the government doubled the height of the border fence in the city, the number of times fire department ambulances transported someone from the border spiked (Prendergast 2013).

To reduce the number of deaths, the Border Patrol created a special Search, Trauma, and Rescue Unit (BORSTAR). Yet the role of BORSTAR is rather controversial because at other times border enforcement agents are the ones responsible for injuring migrants (Jimenez 2009; Isacson, Meyer, and Davis 2013; Martínez, Slack, and Heyman 2013). To mitigate the deadly effects of security policies, humanitarian organizations, such as Humane Borders, Tucson Samaritans, and No More Deaths, among others, took on the task of rescuing unauthorized migrants and providing them first aid (Magaña 2008; Doty 2009). Volunteers build water stations stocked with food, clothing, and first-aid kits and set up medical camps. They also patrol the desert on foot and in vehicles in search for migrants who need help. In situations, when their condition is critical—for example, the border crossers have altered mental
status, difficulty breathing, or snake bites—the volunteers try to persuade migrants to allow them to call 911 and transfer them to local medical facilities. Law enforcement officers at Arizona’s ports of entry also have prosecutorial discretion, which enables them to consider the person’s condition and use humanitarian parole to temporarily admit immigrants for health reasons, even when the patients do not have a passport and a visa allowing them to travel across the border.

But none of them—neither the Border Patrol agents, nor immigrations officers at the ports of entry, nor humanitarian aid volunteers—have the indiscriminate provision of prehospital medical services as the official mandate of their job. In southern Arizona, this task belongs to firefighters, trained as emergency medical technicians and paramedics. The ethical framework that underlies the principles of healthcare distinguishes emergency responders from Border Patrol agents, who, even when trained in first aid, are primarily concerned with enforcing the law. Their affiliation with local governments also sets them apart from humanitarian volunteers who are not accountable to or representative of the state. How do these local public service employees negotiate their seemingly contradictory functions of being part of the state while at the same time rescuing those injured by that state’s policies?

Trauma and Ethics of Distinction

Let us return to the scenario recounted in the beginning of this chapter. Although the man who got trapped under the fence in Nogales was not critically injured, his case illustrates the predicament that injured border crossers face when security logic and humanitarian ethics compete and overlap. In the late 2000s, when this incident occurred, emergency responders were regularly dispatched to help people who tried to breech the border fence, which, in turn, mutilated their bodies. The most graphic of these were amputations caused by the sharp edges of the solid steel panels. Usually, they involved fingers that were cut off as border crossers tried to hold on to the top of the fence before jumping to the ground. This created a special type of jurisdictional problem. While the individual was now on U.S. soil, the person’s amputated fingers most often fell to the other side, into Mexico. Alex, a Mexican American firefighter and emergency medical technician in Nogales, Arizona, remembers: “In some places they used to have openings at the bottom [of the fence] with grates on them for the water to go through. You could still see across and you
could see the fingers and the hands on the other side of the border [in Mexico], and the people were over here [in the U.S.]. Sometimes we would reach over, grab the body part, and put it on ice.” The new slatted border wall, installed in 2011, is taller, reaching between eighteen and thirty feet. Those who try to climb over this bollard-style barrier, generally aided by a ladder on the Mexican side, may fall and fracture their legs or their spine. According to theprehospital emergency medical care protocols in southern Arizona, the mechanism of injury (a fall from a height of over twenty feet) qualifies these patients for air transport by helicopter to the University Medical Center in Tucson, the only Level 1 trauma facility in the region.

The fence is not the only mechanism of injury for transgressive migrant bodies. There are other tools in the Border Patrol’s infamous “prevention-through-deterrence” package. Policies of securitization and militarization on the U.S.-Mexico border tactically deploy both natural and manmade environments—the weaponized terrain—to enforce the jurisdictional boundary between the two countries. This enforcement brutally manifests on the bodies of those who do not have the required documents allowing them to cross through the designated port of entry. People who walk along the Nogales Wash through the underground tunnel get swept away by the turbulent water and may drown (Glionna 2016); those who clandestinely travel by rail suffer leg amputations if they fall onto the tracks under the moving train (Clark 2011); many have been ejected from vehicles as their drivers tried to escape from the Border Patrol pursuing them on dangerously windy roads at night (Caesar 2009); and even more need medical treatment for dehydration, heat stroke, rhabdomyolysis, or hypothermia when they are exposed to extreme temperatures during the walk across the “hostile” desert terrain in rural areas, hoping to avoid checkpoints permanently installed on all northbound roads (De León 2015). Fire departments follow medical protocols that outline what mechanisms of injury and what signs and symptoms warrant transporting patients by air to the trauma center in Tucson. These are typically critical conditions, in which any delay in surgery may be life threatening. The patient’s legal status in the country has no place in medical decision charts.

However, in the border zone, which extends a hundred miles north of the international boundary, policies guiding patient care at fire and rescue departments in different counties and municipalities as well as the discretion of individual first responders affect whether the injuries that unauthorized migrants sustain are read only through a medical or also through a security lens. The law guarantees that anyone who is in critical condition in the United
The border fence that trapped the Mexican man separates the town of Nogales, Arizona, located in Santa Cruz County and estimated to have just over 20,000 residents, over 90 percent of them Hispanic or Latino, from its sister city, Nogales, Sonora, home to at least 300,000 residents. Together they are known to locals as Ambos Nogales (both Nogales), one community divided by a wall. According to the data provided to me by the Nogales Fire Department in 2015, about 10 percent of all emergency calls that they responded to were related to the border, whether it was to take over critical patients from the Mexican ambulances at one of the ports of entry or to help injured undocumented migrants. “We are not Border Patrol. Since he’s on this side of the fence, wherever it is, we had been told to treat that patient,” one fire captain explained. A thirty-year veteran of the Nogales Fire Department continued: “With that issue [referring the patient to the Border Patrol], you are making the EMS people become involved with immigration enforcement.” Yet he also noted that on those rare occasions when the Border Patrol is not yet on scene—usually they are the ones who find injured border crossers and request an ambulance—emergency responders have to call the Border Patrol because that is the only way for the fire department to receive compensation for the medications and supplies used to rescue, treat, and transport unauthorized migrants. Surprisingly, the federal agents are not eager to take custody of the “undocumented aliens” (UDAS), who, unless they are the guides or drug mules, are low on the Border Patrol’s list of priorities. The costs for reimbursing expensive helicopter rides from Nogales to Tucson have strained the federal institution’s budget, to an extent that firefighters I interviewed told me about numerous occasions in which the Border Patrol agents were avoiding taking patients into custody. Local emergency responders arrived on the scene to find federal agents standing next to an injured “fence jumper.” But as in a badly staged performance, claiming that they had not witnessed what
happened nor had video footage to prove an unauthorized entry, agents acted as if they had no proof the person was in the country illegally.  

Nowhere is the tension between security politics, healthcare economy, and medical ethics as evident as in Arivaca, an unincorporated community of about seven hundred residents located eleven miles north of the border in southern Arizona’s Pima County, which is on a popular transit route through the desert between Nogales and Sasabe, used by undocumented migrants and drug smugglers alike. When I conducted fieldwork there in 2015, Arivaca had two emergency medical responders per shift covering a territory of over six hundred square miles. They were called to rescue migrants who fell into abandoned mine shafts, broke their bones when falling down steep crevices in the desert, or lost a lot of fluids during prolonged exposure to extreme heat. They helped men and women, old and young. But the small fire district with a very low budget could not afford to transport and treat such large numbers of injured migrants, and since Arizona has exhausted Medicare’s Section 1011 funds, which allowed them to be compensated for emergency treatment provided to unauthorized border crossers, their only recourse for getting reimbursement for patient care has been through the Border Patrol. Therefore, when called to help undocumented migrants, paramedics ask the Border Patrol to provide a transport authorization request (known as TAR) number, which they include in the patient care reports and which their department later uses to send a bill to the federal agency. A Border Patrol vehicle then follows the ambulance to the hospital, which is often at least an hour away. Unless they are transported by helicopter and need trauma surgery at the University Medical Center in Tucson, patients who are in the Border Patrol’s custody are taken to the hospital’s southern campus and placed in a special security unit. Once released, unauthorized migrants are processed for deportation.

There is no law that obliges emergency responders to contact the Border Patrol when they provide treatment to unauthorized migrants. Most do it because of financial considerations. Some others ask for agents to provide security because they are concerned about their own safety. But in order to decide whether to call the Border Patrol, firefighters and paramedics must first recognize that their patient is in the country illegally. This recognition is not synonymous with racial profiling, though it often reinforces existing stereotypes. Rather, the skills of decoding coordinates of the call and reading signs of the bodies as evidence of illegal entry develop through years of repeated encounters with injured border crossers, allowing emergency respond-
ers to identify those who could cause them harm, such as armed bandits or drug traffickers.

Even far from the international boundary, emergency responders with local experience know with a great degree of confidence when the patient they are treating is an unauthorized border crosser. It comes down to location (on or off the road, home vs. “out there”), time of call (day or night), appearance (“tattered clothing” and the condition of their shoes), and, often, language (Spanish). Commonly, they further distinguish between undocumented migrants and drug smugglers. “We’ve been around for so long that we know when they are drug runners or when they are just coming to find a job,” Carmen, a Hispanic paramedic with the Tubac Fire District, explained to me in 2015. Undocumented migrants “have been out there for days and days.” They are often very dehydrated; they are sick. “And most of the drug runners . . . are still kind of clean, they don’t stink as bad, and they are hydrated. . . . And of course they have the red lines here, where they carry the [drug] packs. So they’ll complain about their shoulders.”

In remote rural areas, and particularly when the first responders are female, they call law enforcement for their own safety and, considering that the closest sheriff’s deputy can be half an hour to an hour away, the Border Patrol usually shows up first. “It’s not the illegals that I am afraid of. It’s the drug runners,” said Tangye, a female Anglo paramedic and an interim chief of the Arivaca Fire District. “The illegals, they are tired, they are grateful for the help.” But paramedics feel less safe in the presence of drug smugglers. “A lot of those people [drug smugglers] carry guns. We don’t carry [bullet-proof] vests. We don’t carry guns, of course.” I spoke to Carmen the day after the press reported that two Mexican nationals (part of a five-man “rip crew” that crossed illegally into the United States seeking to steal drugs from smugglers in the vicinity of the nearby Peck Canyon) had been convicted of murdering Border Patrol agent Brian Terry: “It’s not required for us to call Border Patrol—that’s not my job. But when you see them there . . . and we don’t know what they really want, you just get that gut feeling from some of them that you don’t trust them, unfortunately, a lot of them you don’t. Especially when you know that they were doing something wrong already. And at night. In the middle of nowhere. We don’t have radio service there. We didn’t have cell phone service. There’s nobody else out there. It’s just my partner and I.” Carmen said this to explain why, when she and her partner saw a group of people waving at them in a remote canyon, possibly asking for help, they didn’t stop the ambulance but called the Border Patrol instead, informing the
agents about the situation. She didn't know whether they found the group, nor whether anybody was hurt.

Despite their skills at recognizing types of border crossers, recently emergency medical responders have been struggling to tell them apart. The boundaries separating border crossers into the categories of migrants/patients and smugglers/criminals have been blurred since more migrants are now forced to carry drug loads as a form of payment for the crossing. It’s not easy to sort out who is who in the border zone, and rescue workers are torn between their mandate to help anybody and everybody and the number one rule of arriving on an emergency scene: scene safety. Thus, in some departments, paramedics will not respond to areas that are known corridors used by drug and human smugglers without the escort of the Border Patrol, even if this means delaying medical care or compromising its ethics. In this “Constitution-free zone,” where invoking security justifies the bending of the laws, more and more often local fire departments are not even contacted to provide emergency medical services to injured border crossers. In 2015, the ACLU criticized Santa Cruz and Pima Counties for violating the Equal Protection Clause of the Fourteenth Amendment when the sheriffs’ departments “selectively referred” 911 calls from migrants in distress directly to the Border Patrol, bypassing local first responders.

Uncertain State Actors

Firefighters occupy a legally and ethically ambiguous position vis-à-vis unauthorized migrants that they encounter along the U.S.-Mexico border. As employees of local governments they carry the insignia of power and authority, but they are also witnesses to the human trauma and suffering that federal and state policies cause on the fringes of the post-911 security state. In their work as emergency responders, where they are charged with identifying and treating critical injuries, this task is complicated because firefighters have to read the signs displayed on the bodies of migrants through mismatched ethical and legal lenses and weigh them against their own concerns about personal safety and security.

A firefighter slogan proudly asserts, “We walk where the devil dances,” indicating that by the very nature of their job—to rescue, treat, and transport people who are critically ill or injured—first responders live in a routine state of emergency. But they work in zones of risk and rescue that are un-
evenly produced by broader political and socioeconomic processes. Nowhere is this more visible than on the U.S.-Mexico border, which since the 1990s has become a primary target of the “war on drugs,” the criminalization of migration, and the heightened security buildup. A number of policies on federal and state levels—including, but not limited to anti-immigrant legislation (Arizona’s SB 1070), the transfer of immigration enforcement to local police departments through 287(g) and the Secure Communities Program, surveillance expansion under the Secure Border Initiative, and multiplying internal Border Patrol checkpoints on the roads leading away from the border—affect the lived experiences of local firefighters and paramedics, both limiting and expanding the scope of their work. On the one hand, it is now more difficult to maintain old commitments between communities on both sides of the border, such as assisting Mexican first responders with large fires and other mass casualty incidents in sister cities divided by the fence (Jusionyte 2015b). On the other hand, as we have seen, first responders are often called to help people who bear the direct consequences of increased border securitization and militarization: migrants who suffer traumatic injuries from trying to jump over the steel wall that separates urban neighborhoods, or who become dehydrated or hypothermic while crossing hazardous desert and mountain terrain in an attempt to avoid detection at checkpoints.

The issue is further complicated by the scarcity of resources in southern Arizona and the rising costs of healthcare in the United States. Researchers have documented how their illegal status in the United States affects migrants’ interactions with local government institutions, often limiting their access to vital public resources (Coutin 1999, 2000; Golash-Boza 2012; Menjívar and Abrego 2012; De Genova 2013; Dowling and Inda 2013, among others). In the context of state and local initiatives to police immigrant communities that extend deep into the interior of the country, such as the 287(g) and Secure Communities Program (Coleman 2012; Stuesse and Coleman 2014), they become “entrapped” (Núñez and Heyman 2007). Their precarious position and insecurity prevent them from seeking legal, social, and medical services. This situation is acute in communities adjacent to the border, which, as transit spaces, are characterized by deep ambivalence toward migrants. Residents and local law enforcement personnel often regard migrants in terms of their illegality and reputed association with violence, thereby lacking legitimate claim to rights and limited resources within the communities through which they cross (Vogt 2013). In some areas along the U.S.-Mexico border, calls for medical assistance at the border became “a growing burden” on the finances
and resources of fire and EMS departments. This is true beyond Arizona. For example, a fifth of all calls that the Calexico Fire Department in California responded to in 2011—725 emergencies—were associated with the border. Cited in the *New York Times*, Chief Pete Mercado said the department’s only ambulance would sometimes make ten trips to the port of entry in a given day: “For many of those, he said, the department is not able to collect payment, while the ambulance is rendered unavailable for other emergencies. . . . [According to Mercado:] ‘We’ve absorbed the cost for all these years. I can’t express how difficult it is.’” During interviews that I conducted with fire officials along the Arizona-Sonora border, many shared these same concerns.

Some organizations criticize the U.S. federal government for shifting responsibility of providing emergency treatment to local authorities, encumbered with shrinking resources, thereby placing disproportionate burden for its security and immigration policies on Southwest border counties. Medical emergencies related to escalating violence and security measures have had significant effects on these communities and local fire departments (Dinan 2013; Jusionyte 2015a). Local first responders—firefighters, EMTs, paramedics—as well as nurses and doctors who work in area hospitals, comply with the Emergency Medical Treatment and Active Labor Act, known as EMtAlA. EMtAlA requires that hospitals and emergency personnel provide all patients who arrive in an emergency department with mandatory medical screening examinations; stabilize patients before transit if an emergency medical condition exists; ensure patient safety during the transfer process; and treat anyone who needs emergency medical care regardless of income or immigration status. However, my fieldwork confirms what has been underscored by research conducted in other settings: that relationships among incongruous international and state policies, federal law, medical ethics, disposition of frontline healthcare personnel, and “illegal” patients are fraught with tension (e.g., Rosenthal 2007; Willen 2007; Heyman, Núñez, and Talavera 2009; Castañeda 2011; Chavez 2012; Holmes 2012; Marrow 2012; Willen 2012; Holmes 2013; Huschke 2014) and require distinguishing between universalizing juridical arguments about formal entitlement to health rights and situationally specific moral arguments about deservingness (Willen 2007). These studies examine difficulties that migrants encounter accessing general healthcare services in host countries. Although many of them discuss emergency situations, in which the government mandates provision of lifesaving care to any patient regardless of his or her legal status, they do not focus on medical first responders who work primarily on critical injuries and largely outside of
the hospitals. The burden of reading bodies marked by violence and disease as either worthy of immediate help or a potential source of danger for first responders falls on them.

Historically developed within the military, only fairly recently has prehospital medicine become a civilian field of healthcare, staffed by paid professionals and volunteers (Haller 1992; Hutchinson 1996; Zink 2006). Since the 1970s their presence in neighborhoods across the United States, often integrated with the fire departments, has become routine. The history of the U.S. fire service written by social historians (Maclean 1992; Chetkovich 1997; Tebeau 2003) traces how firefighters, who risk their lives protecting life and property of others, became cultural icons of heroism, respected as the guardians of the community. The development of rescue squads in particular entails “the melding of men and technology into an efficient, lifesaving machine” (Tebeau 2003, 287), balancing on tensions between rationalism and expressiveness, efficiency and passion, modernity and tradition. Their role in responding to the 9/11 attacks, when 343 firefighters died under the collapsing towers in New York City, has further solidified their iconicity as national heroes in the “war on terror” (Rothenbuhler 2005; Donahue 2011). Politically, administratively, and infrastructurally, fire and rescue departments across the United States have been incorporated into civil defense and federal emergency management systems. Yet recent anthropological studies of homeland security and national preparedness (Lakoff 2007; Collier and Lakoff 2008; Lakoff 2008; Fosher 2009; Masco 2014), though they bring attention to emergency response infrastructures, focus on the broader scale of strategic planning and protection of the body politic against catastrophic events rather than on the lived experiences of people who deal with emergency situations on a daily basis.

As other healthcare workers, prehospital emergency responders fit within the broader category of street-level bureaucrats, who wield considerable discretion in the day-to-day implementation of public programs (Lipsky 1980; Maynard-Moody and Musheno 2003; Proudfoot and McCann 2008). Anthropologists interested in the contemporary state have studied contradictions between the formal and the pragmatic in government bureaucracies, as well as the broader tensions between law and cultural norms (see, among others, Herzfeld 1992, 1997; Feldman 2008; Chalfin 2010; Gupta 2012; Hull 2012; Fassin 2013; Jauregui 2013). In the borderlands these “disemic” processes (Herzfeld 1997) can be acutely visible, as Josiah Heyman’s (2000; 2002) extensive research at the ports of entry on the U.S.-Mexico border demonstrates. Emer-
gency responders who rescue unauthorized migrants in southern Arizona also experience conflicts between state policies, on the one hand, and their professional, moral, and ethical obligations, on the other, which places them in an ambiguous position with respect to the law and to the state as political authority (Jusionyte 2015a).

Emergency medical technicians and paramedics have an exceptional status: in their work they disregard questions of legality and criminal background of their patients, which distinguishes them from other agents of the state who are more strictly bound to the law; yet they also occupy a peculiar symbolic and political niche in the national security apparatus. Emergency responders work at the fractures of what Pierre Bourdieu (1994; 1999) calls “the bureaucratic field”—the “splintered space” of the neoliberal state, where the state’s “left hand” (in charge of social functions: public education, health, housing, welfare) and its “right hand” (responsible for enforcing the economic discipline: the police, the courts, the prison) are struggling against each other over the definition and distribution of public goods (Wacquant 2010). According to Loïc Wacquant (2010, 201), these two hands are enmeshed in relations of antagonistic cooperation.

Ethnographic data from fieldwork that I conducted in fire and rescue departments on the U.S.-Mexico border shows how this internal struggle unfolds in practice. More and more often first responders, who rescue and treat unauthorized border crossers, are caught between the imperative of the state, or “security logic,” and the obligations of medicine, the “humanitarian reason” (Fassin 2012). They operate at the point of friction between border enforcement and social-humanitarian policies. But, as we have seen, their decision making is not limited to this conundrum of laws versus ethics, of the framework of security versus their humanitarian mandate. In remote areas along the U.S.-Mexico border, including the long stretches of the Sonoran Desert—inhospitable territory where the passage north is controlled by narco and bandits (Martinez 2014)—emergency responders navigate situations that hurt migrants but that also pose danger to those dispatched to rescue the injured. Their concern for safety adds another layer of complexity to an already difficult scenario of violence, security, and rescue that unfolds in the borderlands.
Conclusion

Neither security infrastructure, such as a higher and longer border fence, nor anti-immigrant policies deter unauthorized migrants from attempting to cross the international boundary separating Mexico from the United States. Motivated by prospective employment in agriculture fields, construction industry, or domestic services; seeking to reunite with family members; or fleeing violence and poverty, they continue to breach the security perimeter, despite the government’s stepped-up attempts to reinforce it in the aftermath of 9/11. This does not mean that the Border Patrol’s strategy of “prevention-through-deterrence” has failed. Although migrants still get across, the buildup of security has made their journey from northern Sonora into southern Arizona particularly dangerous, even deadly. Funneled to travel through the most hazardous physical terrain, usually at the mercy of drug traffickers and bandits who control the routes where the law and its enforcement stretch thin, unauthorized border crossers experience traumatic injury and disease: leg and spinal fractures, amputations, severe dehydration, kidney failure, and rape. The patterns of injuries that migrants incur on the Sonora-Arizona border have been so consistent that they provide evidence of failing immigration and security policies, implicating the state as the perpetrator of violence.

In this chapter I sketched out what happens once unauthorized migrants are subjected to competing ethical and legal mandates that regulate the actions of emergency responders. In southern Arizona, the ill and injured—whether they are long-term residents of towns and ranches or travelers in transit to their destinations farther north—receive prehospital medical care from paramedics employed by the city or county fire departments. Although, as public service workers, they are incorporated into the post-9/11 state apparatus and obliged to follow the political and legal directives that prioritize homeland security over government’s social functions, emergency responders understand their mandate to be that of saving lives, regardless of whether the people they rescue, treat, and transport are U.S. or foreign citizens and whether they are in the country with or without the permission of the federal authorities.

However, as the traumatic injuries that migrants experience have become routine while the costs of healthcare in the United States continue to rise, residents in border communities have become concerned about insufficient resources available to provide lifesaving treatment to everyone in need. The
The federal government, which created the policies and infrastructures that fortified the border, does not have a mechanism to deal with the social and economic effects of “prevention-through-deterrence” on counties and municipalities that provide emergency medical services to those injured by this security strategy. As tensions regarding resources for treating unauthorized migrants in Arivaca, Nogales, and other communities in southern Arizona rise, emergency responders have been forced to participate in immigration policing—their only option for having the federal government pay for the medical services provided to undocumented border crossers has been to call the Border Patrol and ask the federal agents to take their patient into custody.

In this new role, not written into law but widely adopted in practice, emergency responders interpret the signs on the bodies for evidence of illegal border crossing. They note the types and degrees of injuries; they look and listen for social clues; they decode time and space coordinates—all in an attempt to find clues of criminality and pointers of risk. None of these are decisive proof of unauthorized entry or of threat to the safety of firefighters and paramedics, not even when they are sent to remote patches of the borderlands that have fallen under the control of powerful criminal groups and violent bandits. Bodily evidence is not conclusive, and making patient care decisions based on appearances is both ethically and legally problematic. Yet, because of social pressure, financial concerns, and safety considerations, emergency responders who work in the criminalized and marginalized U.S.-Mexico borderlands have learned and now routinely deploy their skills to sort patients into several sociolegal categories, which unofficially complements decision making based on medical protocols. Inadvertently distinguishing the docile bodies of injured migrants from potentially threatening bodies of their guides or from those of drug smugglers further deepens the schism that exists between evidential regimes underlying federal law, medical ethics, and security logics.

Notes

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Unless noted otherwise, the stories are based on ethnographic interviews I conducted with emergency responders during fieldwork in southern Arizona and northern Sonora between May 2015 and June 2016.

According to Dorsey and Díaz-Barriga (2015), citizens who live in the Rio Grande Valley of Texas do not have the right “to be secure in their persons, houses, papers and effects,” which is a violation of the Fourth Amendment. Border Patrol and Texas Department of Public Safety (who now act as the Border Patrol due to 287[G] legislation) can pull citizens over and search cars without cause. The Border Patrol is usually first on scene, so firefighters and paramedics rarely have to decide whether to call them.

If the Border Patrol has no documentation (such as camera footage) of an individual entering the country through an unauthorized passage, they don’t have to take the person into custody, and they often avoid doing so to save costs. Firefighters began writing down the badge numbers of agents and the registration plate numbers of their vehicles, so that they could later prove that they were present, allowing the department to bill the Border Patrol for the call. However, at the federal government’s request they can no longer take down this information, because that could be “compromising their safety,” if, for example, the notes were leaked and the media found out which agents were present on scene.

No emergency responder I have interviewed has ever been threatened or assaulted by an undocumented migrant.

According to a September 2002 report prepared by United States / Mexico Border Counties Coalition and MGT of America, “Medical Emergency: Costs of Uncompensated Care in Southwest Border Counties,” in the early 2000s the costs of providing emergency medical care to undocumented migrants reached $200 million, accounting for an estimated 25 percent of Southwest border hospitals’ and an undetermined percentage of emergency medical service’s (EMS) uncompensated costs (MGT of America 2002).

More detailed information on EMTALA can be found on the website administered by the Centers for Medicare and Medicaid Services (CMS 2012).

Another law from 1996, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), limits Medicaid benefits for undocumented immigrants to emergency health services and non-Medicaid funded public health assistance (such as immunizations, communicable disease treatment).

References


