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How the U.S. Government Fails to Protect Migrant Women's Reproductive Rights in Detention Centers

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How the U.S. Government Fails to Protect Migrant Women’s Reproductive Rights in Detention Centers

Kendall Kohlmeyer*

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I. INTRODUCTION

Today in the U.S., medical abuse occurs in immigration detention centers without patient consent. Instances of medical experimentation have been, and continue to be, forced on Native Americans and women of color throughout the country's history. This note elaborates on a few ways in which the government fails to protect the reproductive rights of women in detention centers and at the border. These include: (1) the failures of Immigration and Customs Enforcement (ICE) officers and detention centers to treat pregnant women humanely; (2) instances in which medical providers, without consequence or oversight, operate on detained women without adequate consent, without knowledge, or against their expressed wishes; and (3) the failures of the federal government and detention facilities to respect detained women's legal right to abortion. ICE is the "federal agency charged with enforcing the nation's immigration laws in a fair and effective manner," which it attempts to do "by securing individuals in custody while they await the outcome of their immigration proceedings and/or removal from the [country]."¹

This note focuses on federal solutions that could alleviate the problems it discusses. While the note discusses issues that occur at both state and federal detention centers, it focuses on federal solutions for a few reasons. First, the laws that govern migrant detention are federal.² Second, this note emanates from the position that the federal government, specifically ICE, should be held legally and morally responsible for all medical treatment given to women in detention centers because they are responsible for necessitating the detention of migrants.³ Although detention facilities fall into three categories: (1) ICE-owned-and-operated, (2) local-, county-, and state-operated contracted through intergovernmental service agreements, or (3) privately contractor-owned-and-operated;⁴ ICE is the ultimate authority that legally mandates immigration enforcement and controls all national civil immigration detention.⁵ Third, the gynecological care and treatment women receive, which often involves serious and complex procedures and conditions, should not vary by state. Rather, migrant women should experience the same level of safety in medical procedures regardless of their geographical location while detained.

1. U.S. IMMIGR. AND CUSTOMS ENF'T, NATIONAL DETENTION STANDARDS FOR NON-DEDICATED FACILITIES 112 (2019) [hereinafter NDS], <https://www.ice.gov/doclib/detention-standards/2019/nds2019.pdf>.

2. U.S. IMMIGR. AND CUSTOMS ENF'T, DETAIN: DETENTION MANAGEMENT (Mar. 31, 2021), <https://www.ice.gov/detain/detention-management>.

3. *Id.* The laws that govern migrant detention state the administrative agency, ICE, falls within the Department of Homeland Security of the U.S. Government. ICE is responsible for enforcing immigration laws and ICE Enforcement and Removal Operations (ERO) "manages and oversees the nation's civil immigration detention system," *id.*

4. *Id.*

5. *Id.*

While this note recommends federal policy solutions, it does not examine legal remedies that may be available to individuals seeking redress for any alleged violations of their rights.⁶ It does not cover laws that relate to neo-natal care, other post-birth procedures or conditions, or any other care, unless they relate directly to fertility, pregnancy, or the ability to carry and birth a healthy child. Instead, this note focuses on preventative policy solutions to advance the ideal that migrants should never again suffer these human rights violations.

II. BACKGROUND AND OVERVIEW

A. HISTORICAL BACKGROUND ON IMMIGRATION DETENTION AND MEDICAL CARE FOR DETAINEES

Detaining aliens at the port of entry was not a norm consistently throughout American history.⁷ In fact, there is little case law from the Supreme Court governing immigration detention. In its first opinion analyzing immigration detention, the Supreme Court in *Nishimura Ekiu v. United States* upheld the Immigration Act of 1891 as constitutional and valid.⁸ Further, it held that the power to supervise, control, and prevent foreign persons' admission to the country was exclusively for the executive and not reviewable by courts as long as they were questions of fact.⁹ Next, the Court in *Wong Wing v. United States* found that detention "is not imprisonment in a legal sense," and does not require due process

6. The note does not, for example, instruct how to recover damages from the injustices committed against those previously detained or how to challenge rights violations currently being committed in detention facilities.

7. Philip L. Torrey, *Rethinking Immigration's Mandatory Detention Regime: Politics, Profit, and the Meaning of "Custody,"* 48 U. MICH. J. L. REFORM 879, 887–91 (2015). The authors detail how detention practices in the U.S. have fluctuated dramatically over time, with Congress deciding to increase detention in the late Twentieth Century in response to rising crime, threats of terrorism, and general worries about the economy when the 1980s recession became the worst the economy had seen post-World-War-II until 2008, *id.* See also Will Maslow, *Recasting Our Deportation Law: Proposals for Reform,* 56 COLUM. L. REV. 309, 360 (1956).

8. *Ekiu v. U.S.*, 142 U.S. 651, 664 (1892). See also *Dep't of Homeland Sec. v. Thuraissigiam*, 140 S. Ct. 1959, 2006 (2020) (Sotomayor, J., dissenting) (restating the principle from *Ekiu* that the Immigration Act's text "prohibited judicial review of executive factfinding alone, and nothing more can be said").

9. *Ekiu*, *supra* note 8, at 663–64. See also *Fong Yue Ting v. U.S.*, 149 U.S. 698, 731 (1893) (stating that since the political departments of government must determine the conditions upon which aliens may remain in the U.S., "the judicial department cannot properly express an opinion upon the wisdom, the policy or the justice of the measures enacted by Congress in the exercise of the powers confided to it by the Constitution over this subject"); *Zadvydas v. Davis*, 533 U.S. 678, 695 (2001) (holding Congress' plenary power to create immigration law "is subject to important constitutional limitations"); *INS v. Chadha*, 462 U.S. 919, 941–42 (1983) (holding Congress' means of implementing immigration laws must be constitutional).

protections.¹⁰ Then, in 1955, the Department of Justice announced a new policy of releasing deportable aliens under bond or parole who “appear to be deserving of their personal liberty,” which effected a “[g]reat reduction” in the number of persons detained in immigration custody.¹¹ Under that policy, detaining migrants became the exception rather than the rule.¹² In 1981, the country returned to mass detaining aliens, “often under overcrowded and unpleasant conditions.”¹³

The standards, or federal regulations pertaining to immigration detention centers, under the section for Medical Care Policy, provide that “detainees shall have access to appropriate medical, dental, and mental health care, including emergency services.”¹⁴ Further, each “facility will have a written plan for the delivery of 24-hour emergency medical and mental health care when no medical personnel are on duty at the facility, or when immediate outside medical attention is otherwise required.”¹⁵ Since the federal regulations leave specific policy-making to each detention facility’s discretion, there is no “standard procedure” for detainees to obtain the medical care to which the standards entitle them.¹⁶

B. HISTORICAL BACKGROUND ON WOMEN AND FORCED STERILIZATIONS IN THE U.S.

Since it is hard to understand why unwanted sterilizations occur, understanding the history of this country’s treatment of women, especially women of color, and migrants may expose some of the motivations of individual doctors and institutions to commit and fail to prevent the life-altering procedures. Even one century after women received the right to vote in the U.S., a majority of Americans agree that women do not yet have

10. *Wong Wing v. U.S.*, 163 U.S. 228, 235 (1896) (holding that “detention, or temporary confinement, as part of the means necessary to give effect to the provisions for the exclusion or expulsion of aliens would be valid . . . Detention is a usual feature of every case of arrest on a criminal charge, even when an innocent person is wrongfully accused; but it is not imprisonment in a legal sense”). The Court did not state why detention does not legally constitute imprisonment, but it appears that it rests this interpretation on the fact that criminal defendants are also detained awaiting trial after having been accused of a crime, even when they are wrongfully accused. This is not persuasive because many detained immigrants have not been accused of a crime and deserve freedom from the disappointing conditions in detention centers, as this note will argue.

11. Honorable Herbert Brownell, Jr., Attorney General of the U.S., Address at the American Council of Voluntary Agencies Committee on Migration and Refugee Problems’ American Immigration Conference: Humanizing the Administration of the Immigration Law 1–2 (Jan. 6, 1955) (transcript available at the U.S. Department of Justice website).

12. *Id.* at 2. See also Peter H. Schuck, *The Transformation of Immigration Law*, 84 COLUM. L. REV. 1, 29 (1984).

13. Schuck, *supra* note **Error! Bookmark not defined.**

14. NDS, *supra* note 1.

15. NDS, *supra* note 1 at 116.

16. NDS, *supra* note 1 at 113.

equal rights compared to men.¹⁷ According to a Pew Research Center survey, “more say that feminism helped white women a lot (32%) than say [it has] done the same for Black [women] (21%),” and notably, only half as many surveyed say that feminism has helped the lives of Hispanic women (15%) compared to white women (32%).¹⁸ Only 10% feel that feminism has dramatically helped women in poverty.¹⁹

Extensive research supports Americans’ perceptions that socioeconomic status impacts health outcomes in the U.S.²⁰ Three important social determinants contribute to health inequality: gender, ethnicity, and social class.²¹ Migrant women are subject to the interplay between at least two of these social determinants (gender and ethnicity), and these, in combination with their lower economic status places them in an inferior social class. Arguably, women in detention suffer the compounded health consequences of all three categories because American society historically treats undocumented status negatively.

The United States has an extensive history of subjecting women of color, indigenous women, and migrant women to gynecological procedures and experiments without their consent.²² Most appallingly, physicians experimented on enslaved women and often received high praise for their “work,” including J. Marion Sims, the “father of gynecology.”²³ Enslaved

17. JULIANA HOROWITZ & RUTH IGIELNIK, A CENTURY AFTER WOMEN GAINED THE RIGHT TO VOTE, MAJORITY OF AMERICANS SEE WORK TO DO ON GENDER EQUALITY 4, (Pew Rsch. Ctr. 2020).

18. *Id.* at 7.

19. *Id.*

20. NANCY ADLER, ET AL., REACHING FOR A HEALTHIER LIFE: FACTS ON SOCIOECONOMIC STATUS AND HEALTH IN THE U.S., (The John D. and Catherine T. MacArthur Found. Rsch. Network on Socioeconomic Status and Health, 2009).

21. Alicia Llácer, et al., *The Contribution of a Gender Perspective to the Understanding of Migrants’ Health*, 61 J. OF EPIDEMIOLOGY AND CMTY. HEALTH ii4-ii10, ii6 (2007). Stating additionally that gender, ethnicity, and social class “are closely interrelated and are each associated with specific risks to health and differential vulnerability during the population’s lifetime,” *id.*

22. Kathleen Bachynski, *American Medicine Was Built on the Backs of Slaves. And it Still Affects How Doctors Treat Patients Today*, WASH. POST (June 4, 2018), <https://www.washingtonpost.com/news/made-by-history/wp/2018/06/04/american-medicine-was-built-on-the-backs-of-slaves-and-it-still-affects-how-doctors-treat-patients-today/>. Explaining effect of racist ideas from historically prominent physicians, such as that Black people had less sensitive nervous systems and therefore did not feel pain like white people. *id.* See also Erin Blakemore, *The Little-Known History of the Forced Sterilization of Native American Women*, JSTOR DAILY (Aug. 25, 2016), <https://daily.jstor.org/the-little-known-history-of-the-forced-sterilization-of-native-american-women/>. This history relates directly to immigrant women currently placed in U.S. detention centers for at least two reasons: (1) many migrant women are women of color and therefore still suffer from the racist ideas that continue to permeate modern medicine in the U.S.; and (2) migrant women today are subject to many of the same types of treatment historically forced upon women who could not consent in the past—such as enslaved women—including forced sterilization, gynecological experimentation, and failures to offer anesthesia, *id.*

23. Brynn Holland, *The ‘Father of Modern Gynecology’ Performed Shocking Experiments on Enslaved Women*, HISTORY (Aug. 29, 2017),

women did not have the option to say no to his experiments, and Sims's practices contributed to modern racial biases in obstetrics, including the false belief that Black women have a higher pain threshold than white women.²⁴ More recently, in the 1960s and 1970s, the Indian Health Service (IHS) committed forced sterilizations of thousands of Native American women.²⁵ The U.S. government created IHS and allegedly sterilized at least one-quarter of Native American women of ages fifteen to forty-four in the 1970s.²⁶ In total, eugenics practices led to over 60,000 sterilizations in the twentieth century throughout the United States.²⁷

III. ISSUES

The mass detention of migrants makes possible each of the problems examined in this section. If women were not placed in immigration detention, these issues could be avoided. Specifically, if women were not placed in detention pursuant to federal civil immigration enforcement authority, they would be free to seek medical care of their choosing if, or when, they believed they required it. Increased lengths of immigration detentions also exacerbate medical problems because the longer women are detained, the higher the likelihood that they will need or seek medical care while detained.

The reproductive-related injustices committed against women in U.S. detention centers constitute improper medical treatment and human rights violations that have been carried out with legally insufficient informed consent. In part, these issues are possible due to the lack of federal regulations over medical care that must be provided to migrants in detention.

<https://www.history.com/news/the-father-of-modern-gynecology-performed-shocking-experiments-on-slaves>. The article describes that Dr. Sims, a renowned medical doctor of his time, was President of the American Medical Association in 1876 and in 1880 became President of the American Gynecological Society, which he helped found. The doctor experimented on at least ten enslaved Black women without anesthesia, even when he inflicted 30 painful surgeries on *one* enslaved woman, whereas he later treated white women with anesthesia, *id.* See also Sarah Lynch, *Fact Check: Father of Modern Gynecology Performed Experiments on Enslaved Black Women*, USA TODAY (June 20, 2020), <https://www.usatoday.com/story/news/factcheck/2020/06/19/fact-check-j-marion-sims-did-medical-experiments-black-female-slaves/3202541001/>.

24. Maura Hohman, *How This Black Doctor is Exposing the Racist History of Gynecology*, TODAY (June 29, 2020), <https://www.today.com/health/racism-gynecology-dr-james-marion-sims-t185269>.

25. Blakemore, *supra* note 22.

26. Jane Lawrence, *The Indian Health Service and the Sterilization of Native American Women*, 24 AM. INDIAN Q. 400, 400–01 (2000).

27. Alexandra Minna Stern, *Forced Sterilization Policies in the U.S. Targeted Minorities and Those with Disabilities—and Lasted into the 21st Century*, UNIV. OF MICH. INST. FOR HEALTHCARE POL'Y AND INNOVATION (Sept. 23, 2020), <https://ihpi.umich.edu/news/forced-sterilization-policies-us-targeted-minorities-and-those-disabilities-and-lived-21st>.

The Immigration and Nationality Act, a federal statute enacted by Congress, grants the Secretary of the HHS the authority to promulgate regulations for the medical evaluations performed before aliens may be admitted to the United States.²⁸ The title of this federal statute, “Admission Qualifications for Aliens: Travel Control of Citizens and Aliens,” supports that the reason HHS retains authority to regulate such evaluations is for the benefit of overall public health in the U.S., rather than for the benefit of the individuals receiving evaluations.²⁹ The statutory language that appears at 8 U.S.C. Section 1182(a) makes this intent more explicit by stating that these medical examinations serve the purpose of determining the disease status of individuals that may place them in an “inadmissible class.”³⁰ Under the statute, individuals found to belong to an “inadmissible class” are categorically “ineligible to receive visas and ineligible to be admitted to the [U.S.]”³¹ As an exercise of its authority, the Secretary of HHS promulgated “Medical Examination of Aliens,” found in the Code of Federal Regulations.³²

The HHS does not provide any further medical standards beyond mandating medical examinations for the protection against the spread of disease at the border. Thus, the HHS does not regulate the medical care of migrants in any meaningful way for the benefit of the individuals receiving examination. The only federal attempt to standardize the medical care provided to detained migrants can be found in Part 4.3 of the ICE National Detention Standards for Non-Dedicated Facilities.³³ The entire section comprises 15 pages,³⁴ and it dedicates less than two to “Women’s Medical Care.”³⁵ The document does not necessarily provide standards of care to be given, but mostly provides a list of the types of care that should be available related to pregnancy, contraception, abortion, and initial examination.³⁶

A. PREGNANT WOMEN AND IMMIGRATION DETENTION

According to HHS, pregnant women require regular checkups to ensure their own health and safety, and that of their babies, by spotting problems that may occur and preventing issues with delivery.³⁷ The Office on

28. 8 U.S.C. § 1182 (a)(1)(A). *See also* 8 U.S.C. § 1222 (INA 232). The statute grants mandatory authority to the U.S. Public Health Service to conduct all medical examinations for “physical and mental defect or disease,” *id.*

29. 8 U.S.C. § 1182 (a).

30. *Id.*

31. *Id.*

32. 42 C.F.R. § 34.

33. *See* NDS, *supra* note 1.

34. *See id.*

35. *Id.* at 124-25.

36. *See id.*

37. *You’re Pregnant: Now What? Prenatal Care and Tests*, OFF. OF THE ASSISTANT SEC’Y FOR HEALTH, U.S. DEP’T OF HEALTH AND HUM. SERVS.: OFF. ON WOMEN’S HEALTH,

Women's Health under the HHS recommends routine checkups monthly through week twenty-eight of pregnancy, twice monthly for weeks twenty-eight through thirty-six, and then weekly until birth.³⁸ This does not apply to pregnancies deemed high-risk, during which women must visit their doctors more frequently.³⁹

The Obama administration enacted a policy that stated "absent extraordinary circumstances or [legally] mandatory detention, pregnant women will generally not be detained by ICE."⁴⁰ The policy additionally provided that in circumstances where pregnant women must be detained, they will be "re-evaluated regularly to determine if continued detention is warranted."⁴¹ Unfortunately, the Trump administration overturned the previous practice of generally not detaining pregnant women.⁴² On December 14, 2017, ICE issued internal memo 11032.3, which replaced the Obama-era directive and became public on March 29, 2018.⁴³ Now, instead of detaining only those pregnant women who have serious criminal records, pose serious flight risks, or meet other safety-related criteria, ICE will generally detain women until their third trimester.⁴⁴ ICE stated that, under its new policy, "ICE is ending the presumption of release," and admits that it will even detain pregnant women during the third trimester of pregnancy in extraordinary circumstances.⁴⁵

<https://www.womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests> (last visited Jan. 30, 2019) [hereinafter *Prenatal Care*].

38. *Id.* See also Mayo Clinic Staff, *Prenatal Care: 3rd Trimester Visits*, MAYO CLINIC (Aug. 7, 2020), <https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/prenatal-care/art-20045660>.

39. *Prenatal Care*, *supra* note 37. "High-risk" pregnancies are those with a greater chance of complications, which can be due to the woman's age, weight, health conditions prior to pregnancy, etc., *id.*

40. Memorandum from the U.S. Immigration and Customs Enforcement on Identification and Monitoring of Pregnant Detainees (Aug. 15, 2016) (on file with U.S. Dept. of Homeland Security).

41. *Id.*

42. Alan Gomez, *ICE to Hold More Pregnant Women in Immigration Detention*, USA TODAY (Mar. 30, 2018), <https://www.usatoday.com/story/news/nation/2018/03/29/ice-hold-more-pregnant-women-immigration-detention/469907002/>. See also ACLU Comment on New ICE Policy that Allows Detention of Pregnant Women, AM. CIV. LIBERTIES UNION, <https://www.aclu.org/press-releases/aclu-comment-new-ice-policy-allows-detention-pregnant-women> (last visited Dec. 21, 2021).

43. U.S. IMMIGR. AND CUSTOMS ENF'T, ICE DIRECTIVE 11032.3: IDENTIFICATION AND MONITORING OF PREGNANT DETAINEES (2017), https://www.ice.gov/sites/default/files/documents/Document/2018/11032_3_PregnantDetainees.pdf.

44. Gomez, *supra* note 42. See also Abigail Abrams, *ICE Will Now Detain Pregnant Women Because of President Trump's Executive Order*, TIME (Mar. 29, 2018), <https://time.com/5221737/ice-detain-pregnant-immigrants-donald-trump/>.

45. FAQs: Identification and Monitoring of Pregnant, Postpartum or Nursing Individuals, U.S. IMMIGR. AND CUSTOMS ENF'T, <https://www.ice.gov/directive-identification-and-monitoring-pregnant-postpartum-or-nursing-individuals> (last visited Dec. 20, 2021).

In the first fiscal year that the Trump administration promulgated internal memo 11032.3, the number of pregnant women who were detained increased by 35% from the year before the change was enacted.⁴⁶ The U.S. Department of Homeland Security (DHS) detained over 2,000 pregnant women in 2018.⁴⁷ This has contributed to unsanitary and dehumanizing conditions for the women who have been affected.

In response to the policy change, the U.S. Government Accountability Office published a ninety-seven-page report in 2020 entitled, "Immigration Detention: Care of Pregnant Women in DHS Facilities."⁴⁸ The report examines DHS data and summarizes interviews from fourteen pregnant women who were detained or released by DHS.⁴⁹ The most common complaint against ICE within the report was its failure to provide medical care.⁵⁰ Two pregnant women suffered solitary confinement in ICE facilities, one of them for over four months.⁵¹ Each of the women interviewed said "they slept on the floor and [did not] receive adequate nutrition and snacks, despite being pregnant."⁵²

One woman awaiting ICE processing in 2020 was forced to give labor while standing up, wearing pants, and leaning against a trash can while her two young daughters watched.⁵³ Another woman, Rubia Mabel Morales-Alfaro, was detained while pregnant and claimed that negligence and poor medical care while she was detained caused her to miscarry.⁵⁴ In a suit filed against ICE and the private prison company that operates an immigration detention center on behalf of ICE, the asylee's complaint alleges that when she experienced pain and bleeding, a nurse prescribed Tylenol and told Ms.

46. Ema O'Connor, *Senators Call For An Investigation Of Alleged Mistreatment Of Pregnant Women In Immigration Detention*, BUZZFEED NEWS (July 13, 2018), <https://www.buzzfeednews.com/article/emaconnor/senators-call-for-an-investigation-of-alleged-mistreatment>.

47. Dorothy Atkins, *GAO Releases Report Detailing Pregnant Migrant Mistreatment*, LAW360 (Apr. 22, 2020, 7:48 PM), <https://www.law360.com/articles/1266343/gao-releases-report-detailing-pregnant-migrant-mistreatment>.

48. U.S. GOV'T ACCOUNTABILITY OFF., GAO-20-330, CARE OF PREGNANT WOMEN IN DHS FACILITIES (2020) [hereinafter CARE OF PREGNANT WOMEN]. According to its website, the Government Accountability Office provides "non-partisan information that can be used to improve government" upon the request of congressional committees or subcommittees or when statutorily required by public laws or committee reports. *What GAO Does*, U.S. GOV'T ACCOUNTABILITY OFF.: ABOUT, <https://www.gao.gov/about/what-gao-does> (last visited Dec. 20, 2021).

49. CARE OF PREGNANT WOMEN, *supra* note 48, at Highlights.

50. Atkins, *supra* note 47.

51. *Id.*

52. *Id.*

53. Ema O'Connor, *A Woman Gave Birth in A Border Patrol Station Still Wearing Her Pants. Now The Agents Involved Are Being Accused Of Abuse*, BUZZFEED NEWS (Apr. 9, 2020), <https://www.buzzfeednews.com/article/emaconnor/pregnant-woman-birth-border-patrol-aclu-complaint>.

54. Suzanne Monyak, *ICE Aims To Dodge Liability Over Asylee's Miscarriage*, LAW360 (Aug. 11, 2020), <https://www.law360.com/articles/1300093/ice-aims-to-dodge-liability-over-asylee-s-miscarriage>.

Morales-Alfaro that this was normal.⁵⁵ When Ms. Morales-Alfaro was finally taken to a hospital because she collapsed two weeks later, medical staff stated that her miscarriage could have been prevented if she had received medical attention sooner.⁵⁶

Pregnant women face similar issues of insensitive and inhumane treatment in criminal detention. In prisons, women and mothers face several challenges during pregnancy and after delivery that the Senate is attempting to mitigate with a recently proposed bill.⁵⁷ Currently, “no mandatory standards for prenatal and pregnancy care” exist to protect incarcerated women and ensure their proper care.⁵⁸ The proposed legislation, Protecting the Health and Wellness of Babies and Pregnant Women in Custody Act, seeks to address this issue by providing minimum standards for the health care offered to pregnant women during pregnancy, labor, and recovery.⁵⁹ While this law would begin to close the important gap for pregnant women, it should be noted that this type of federal standard should have existed long ago for women in jails, prisons, and detention centers.

B. NON-CONSENTED STERILIZATIONS OF DETAINED WOMEN

As used in this note, the “sterilization” of a woman refers to a hysterectomy or an oophorectomy. A hysterectomy is a surgery to remove the uterus.⁶⁰ An oophorectomy is a surgery to remove the ovaries.⁶¹ After undergoing these procedures, a woman cannot become pregnant.⁶² A hysterectomy may sometimes be medically necessary for a woman with one of the following conditions: uterine fibroids, heavy or unusual vaginal bleeding, uterine prolapse, endometriosis, adenomyosis, and cancer or precancer of certain organs.⁶³

Given this medical background on the seriousness of the operation, it is difficult to understand why immigration detention facilities allow doctors to perform it so frequently. Unfortunately, some migrant women in Georgia did not realize how rarely the invasive procedure is medically necessary

55. *Id.*

56. *Id.*

57. Grace Asiegbu, *Pregnant Women in Prison Could See Health Care Improve Under House Legislation*, SACRAMENTO BEE (Sept. 17, 2020), <https://www.sacbee.com/news/politics-government/article245804670.html>.

58. *Id.*

59. H.R. 7718, 116th Cong. (2020).

60. *Hysterectomy and Oophorectomy: Should I Use Estrogen Therapy (ET)?*, UNIV. OF MICH. HEALTH SYS., <https://www.uofmhealth.org/health-library/tn9713> (last visited Dec. 21, 2020).

61. *Id.*

62. SARAH M. TEMKIN, *HYSTERECTOMY: A FACT SHEET FROM THE OFFICE ON WOMEN’S HEALTH 2* (Off. on Women’s Health, Dec. 4, 2014).

63. *Id.* at 1.

until after the doctor completed their hysterectomies.⁶⁴ One potential explanation for performing surgeries that are not medically necessary is the high potential for financial compensation. When independent doctors treat ICE detainees, they are paid per procedure, at thousands of dollars for each invasive surgery.⁶⁵

1. Legal Requirements of Informed Consent

In a medical malpractice context, to obtain legally recognizable informed consent, a physician must disclose certain risks and outcomes of a proposed course of treatment. In some states, a physician must disclose information that a reasonable patient would want to know under the circumstances.⁶⁶ For example, California adopted this type of standard and imposes on physicians a duty to disclose “the amount of knowledge a patient needs in order to make an informed choice.”⁶⁷ In other words, a physician must provide all information the physician knows, or should know, that a reasonable person in the patient’s position would consider significant in deciding whether to undergo the recommended procedure.⁶⁸ In states that do not adopt California’s standard, physicians must disclose the information that a reasonable physician would disclose to the patient under similar circumstances. For instance, Wisconsin applies the reasonable physician standard.⁶⁹

In contrast, the federal requirements for informed consent in a research setting are much more thorough and stringent.⁷⁰ The General Requirements for Informed Consent under the Code of Federal Regulations require at least nine “[b]asic elements of informed consent.”⁷¹ These include a description of reasonably foreseeable risks or discomforts, any reasonably expected benefits, and a disclosure of appropriate alternative procedures or courses of treatment.⁷²

2. Inadequate Informed Consent Obtained in Practice

Care currently provided to women in detention centers often fails to meet, or even attempt to meet, any of these standards in important ways.⁷³

64. Caitlin Dickerson, et al., *Immigrants Say They Were Pressured into Unneeded Surgeries*, N.Y. TIMES (July 17, 2020), <https://www.nytimes.com/2020/09/29/us/ice-hysterectomies-surgeries-georgia.html>.

65. *Id.*

66. *Truman v. Thomas*, 27 Cal. 3d 285, 291 (1980).

67. *Id.*

68. *Id.* See also *Flores v. Liu*, 60 Cal. Ct. App. 5th 278, 292–93 (2021).

69. See *Jandre v. Wis. Injured Patients & Families Comp. Fund*, 340 Wis. 2d 31, 78 (2012) (holding physicians are held to the standard “of a hypothetical, reasonable physician in similar circumstances”).

70. 45 C.F.R. § 46.116.

71. 45 C.F.R. § 46.116(b).

72. 45 C.F.R. § 46.116(b).

73. See E-Mail from Project South to author (Sept. 14, 2020) (on file with author). Detailing lack of medical care, unsafe work practices, and absence of adequate protection

These include: (1) failing to obtain interpreters when patients do not understand the language spoken by their providers; (2) failing to communicate which medical procedures patients will undergo prior to the start or completion of the procedures; and (3) coercing women to consent.⁷⁴

One brave whistleblower shared facts that support the occurrences of these injustices and many others relating to the lack of proper treatment around COVID-19 precautions.⁷⁵ The whistleblower, Dawn Wooten, is a licensed practice nurse employed by the Irwin County Detention Center, a Georgia detention facility.⁷⁶ Ms. Wooten revealed that nurses try to communicate “to detained immigrants by simply googling Spanish or by asking another detained immigrant to help interpret rather than using the language line as medical staff are supposed to.”⁷⁷ She stated that when the staff used language lines, they would often discover underlying conditions.⁷⁸ The lack of respect for patients shown by failing to use proper language assistance is clear; Ms. Wooten says that Latinos receive the worst treatment in the facility.⁷⁹

She also shared that “it was common practice for the sick call nurse to shred medical request forms from detained immigrants” who requested medical assistance and nurses “sometimes fabricated records such as vital signs without ever seeing the individual.”⁸⁰ According to Ms. Wooten, immigrants were encouraged to use the medical request forms for faster resolution of their complaints. She stated she “has seen the sick call nurse shred an entire box worth of forms without looking at them.”⁸¹

In addition, Ms. Wooten shared that she observed a woman ask what type of procedure would be done to her only to receive three different responses from different providers.⁸² When she tried to tell the providers about the hysterectomy, she was going to receive by saying, “something isn’t right; that procedure isn’t for me,” the nurses yelled at her.⁸³ Unfortunately, this type of scenario is common. Moreover, some women who are detained do not learn they will be fully or partially sterilized until the procedure is complete. Many women told Ms. Wooten that they went to the doctor and received hysterectomies, but that they did not understand why they were going to the doctor.⁸⁴

against COVID-19 for detained immigrants and employees alike at the Irwin County Detention Center, *id.*

74. *Id.* at 19–20.

75. *Id.* at 23–24.

76. *Id.* at 1–2.

77. *Id.* at 20.

78. *Id.* at 17.

79. *Id.*

80. *Id.* at 15.

81. *Id.*

82. *Id.* at 20.

83. *Id.*

84. *Id.* at 19.

3. Forced Partial and Complete Hysterectomies

Seventeen or more women detained at the Irwin County Detention Center where Ms. Wooten worked received unnecessary gynecological medical procedures, “often without appropriate consent or knowledge, and *with the clear intention of sterilization*”.⁸⁵ Congresswoman Pramila Jayapal, after speaking with attorneys for the migrants detained at the facility, and other lawmakers compared the unwanted hysterectomies to eugenic-sterilization laws from the 1900s.⁸⁶ In the lawmakers’ words, “reports of mass hysterectomies cause grave concern for the violation of the bodily autonomy and reproductive rights of detained people. Everyone, regardless of their immigration status . . . deserves to control their own reproductive choices.”⁸⁷

A woman detained at the same facility said she knew that one doctor had performed hysterectomies on at least five women detained at the facility between October and December 2019.⁸⁸ She likened her experiences at the detention facility to “an experimental concentration camp,” after meeting women who were confused as to why they had had surgeries; “It was like they’re experimenting with our bodies.”⁸⁹

Ms. Wooten shared that the doctor accused of performing unnecessary sterilizations once took “out the wrong ovary” when an immigrant woman needed one removed because of a cyst.⁹⁰ The patient “said she was not all the way out under anesthesia and heard [the doctor] tell the nurse that he took the wrong ovary,” so he needed to take out the other one.⁹¹ The young woman ended up with an unwanted full hysterectomy.⁹² Ms. Wooten said “[s]he still wanted children—so she has to go back home now and tell her husband that she can’t bear [children].”⁹³

Dr. Mahendra Amin, the ICDC’s “primary gynecologist,” according to ICE officials, treated all sixteen women who were interviewed by the New York Times because they raised concerns about the gynecological

85. Suzanne Monyak, *Lawmakers Want Medical Abuse Claims at ICE Facility Probed*, LAW360 (Sept. 16, 2020), <https://www.law360.com/articles/1310714/lawmakers-want-medical-abuse-claims-at-ice-facility-probed> (emphasis added). *See also* Jennifer Doherty, *DHS To Probe Forced Hysterectomy Claims At Ga. ICE Facility*, LAW360 (Sept. 17, 2020), <https://www.law360.com/articles/1311387/dhs-to-probe-forced-hysterectomy-claims-at-ga-ice-facility>.

86. Monyak, *supra* note 85.

87. *Id.*

88. Email from Project South, *supra* note 73, at 18.

89. *Id.* at 19. The federal standards for medical care at detention facilities states, “[d]etainees shall not be used in any medical, pharmaceutical, or cosmetic experiments or research,” but do not appear to receive meaningful enforcement, according to these facts shared by women at the facilities. NDS, *supra* note 1, at 121.

90. Email Project South, *supra* note 73, at 19.

91. *Id.*

92. *Id.*

93. *Id.*

treatment he provided.⁹⁴ When five gynecologists, four of whom are board-certified,⁹⁵ reviewed the cases of the detained women, they found that Dr. Amin “consistently overstated the size or risks associated with cysts or masses attached to his patients’ reproductive organs,” and that small or benign cysts usually do not require surgery.⁹⁶ The gynecologists noted he “seemed to consistently recommend surgical intervention, even when it did not seem medically necessary . . . and nonsurgical treatments options were available.”⁹⁷

One of the gynecologists, Dr. Sara Imershein, called his diagnoses and procedures “poorly supported” and “not well documented.”⁹⁸ Although the charts of most women contained symptoms that could justify surgery, some of the women interviewed said they neither experienced nor reported the symptoms to Dr. Amin.⁹⁹ Dr. Imershein said even if they had reported those symptoms, there would have been alternatives to try before surgery.¹⁰⁰ Another reviewing gynecologist, Dr. Deborah Ottenheimer, said “[Dr. Amin] is overly aggressive in his treatment and does not explore appropriate medical management before turning to procedures or surgical intervention.”¹⁰¹

4. Resulting Ethical and Practical Concerns

Physicians hold sacred the Hippocratic Oath, by which they swear to uphold certain ethical principles, such as treating patients to the best of their ability.¹⁰² Most medical students take the Hippocratic Oath when they graduate from medical school.¹⁰³ The World Medical Association (WMA) adopted the Declaration of Geneva, the “Modern Hippocratic Oath,” for the first time in 1947.¹⁰⁴ Most recently, the WMA amended the Declaration and

94. Dickerson, et al., *supra* note 64.

95. Doctors do not need to achieve board certification to practice medicine or any specialty within medicine, but if they choose to do so, it demonstrates their enhanced skills and expertise. *About Certification Matters*, AM. BD, OF MED. SPECIALTIES, <https://www.certificationmatters.org/about/> (last visited Dec. 20, 2021).

96. Dickerson, et al., *supra* note 64.

97. *Id.*

98. *Id.* Dr. Imershein serves as a clinical professor at George Washington University and as the Washington, D.C. chair of the American College of Obstetricians and Gynecologists, *id.*

99. *Id.*

100. *Id.*

101. *Id.* Dr. Ottenheimer is a forensic evaluator and instructor at the Weill Cornell Medical School Human Rights Clinic, *id.*

102. Jay W. Marks, *Medical Definition of Hippocratic Oath*, MEDICINET, https://www.medicinenet.com/hippocratic_oath/definition.htm (last visited Dec. 21, 2021).

103. Rachel Hajar, *The Physician’s Oath: Historical Perspectives*, 18 HEART VIEWS 4, 154–59 (2017).

104. *Declaration of Geneva: The “Modern Hippocratic Oath,”* WORLD MEDICAL ASS’N, <https://www.wma.net/what-we-do/medical-ethics/declaration-of-geneva/> (last visited Dec. 20, 2021).

entitled it, “The Physician’s Pledge.”¹⁰⁵ The international policy made several significant changes to previous versions.¹⁰⁶ Importantly, it states, “I will respect the autonomy and dignity of my patient; I will maintain the utmost respect for human life,” and “I will not use my medical knowledge to violate human rights and civil liberties.”¹⁰⁷

The American Medical Association adopts its Principles of Medical Ethics as “standards of conduct that define” proper physician behavior.¹⁰⁸ The first two principles include, “[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights,” and “[a] physician shall . . . be honest in all professional interactions.”¹⁰⁹ Equally important, the fourth principle states, “[a] physician shall respect the rights of patients.”¹¹⁰

The same legal standards for informed consent guide all physicians when they provide care to any patient, regardless of, for example, where they receive care. Certainly, the failure to obtain genuinely informed consent constitutes a breach of several professional duties of physicians, such as those to provide care “with compassion and respect for human dignity and rights,”¹¹¹ and to respect “the autonomy and dignity of [a] patient.”¹¹² The WMA’s 2017 policy’s assertion that physicians will not use their medical knowledge to violate human rights and civil liberties,¹¹³ perfectly applies to the issue of obtaining informed consent from patients in vulnerable positions, such as women seeking refuge in a new or unfamiliar country.

No existing laws support the proposition that physicians escape legal, ethical, or professional standards when providing treatment to women in detention centers. If anything, ethical and professional standards expand most completely in situations where it would be easiest or most tempting to ignore them—such as where migrant women in remote locations depend exclusively on one provider for most or all the medical care that they receive. The geographical location of a patient, such as their temporary residence in a detention center, does not alter the physician’s sworn

105. *Declaration of Geneva: The Physician’s Pledge*, WORLD MEDICAL ASS’N, <https://www.wma.net/policies-post/wma-declaration-of-geneva/> (last visited Dec. 21, 2021).

106. Tanya Albert Henry, *Global Physician’s Ethics Pledge Gets Biggest Makeover in Decades*, AM. MEDICAL ASS’N (Nov. 20, 2017), <https://www.ama-assn.org/delivering-care/ethics/global-physician-ethics-pledge-gets-biggest-makeover-decades>.

107. *Declaration of Geneva: The Physician’s Pledge*, *supra* note 105.

108. Hajar, *supra* note 103.

109. *Id.* See also *Principles of Medical Ethics*, AM. MEDICAL ASS’N, <https://www.ama-assn.org/about/publications-newsletters/ama-principles-medical-ethics> (last visited Oct. 8, 2021).

110. *Id.*

111. *Id.*

112. *Declaration of Geneva: The Physician’s Pledge*, *supra* note 105.

113. *Id.*

obligation to respect patient rights and dignity and obligation to be honest. Likewise, the patient's immigration status should not alter these obligations when their physician provides care within U.S. borders. Otherwise, the legal and ethical standards binding physicians would be futile if they did not apply equitably to all patients. This would quickly exacerbate existing disparities in the provision of medical care and directly contradict the concepts contained by the oaths themselves.

C. REFUSALS TO RESPECT THE LEGAL RIGHTS OF WOMEN TO OBTAIN ABORTIONS

When the Supreme Court in *Roe v. Wade* held that the right to privacy includes a woman's decision to terminate her pregnancy, the Court found that "[t]he detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent."¹¹⁴ There, the Supreme Court struck down as unconstitutional a state law that made obtaining an abortion illegal with the single exception of those "for the purpose of saving the life of the mother."¹¹⁵ ICE's national detention standards state that ICE will allow abortions in the narrow circumstances of rape, incest, or when carrying the fetus to term would endanger the mother's life.¹¹⁶ This is only a minor expansion from the law the Supreme Court held unconstitutional in *Wade*.

More concerning than the very narrow circumstances in which ICE's national detention standards allow women the choice to terminate a pregnancy, detention centers do not necessarily abide by the legal standards. After a federal judge granted one woman the right to obtain an abortion, the Trump administration refused to let her leave the premises to undergo the procedure.¹¹⁷ The Office of Refugee Resettlement (ORR), where the woman was being detained, declared that facilities "are prohibited from taking any action that facilitates an abortion without direction and approval of the ORR." When this was challenged, a district court judge granted the woman, and others similarly situated, a preliminary injunction, holding that the "ORR may not create or implement any policy that strips [pregnant immigrant minors] of their right to make their own reproductive choices."¹¹⁸ Though the Supreme Court granted certiorari, it found the case moot because the woman eventually obtained the abortion.¹¹⁹

114. *Roe v. Wade*, 410 U.S. 113, 153 (1973).

115. *Id.* at 164.

116. NDS, *supra* note 1, at 125–26.

117. *Judge Orders Trump Administration to Stop Blocking Abortion for Two Immigrant Women*, AM. CIV. LIBERTIES UNION (Dec. 19, 2017), <https://www.aclu.org/press-releases/judge-orders-trump-administration-stop-blocking-abortion-two-immigrant-women>.

118. *Garza v. Hargan*, 304 F.Supp. 3d 145, 165 (2018).

119. *Azar v. Garza*, 138 S. Ct. 1790, 1792 (2018).

IV. PROPOSED SOLUTIONS

Federal solutions to the issues raised above may be created as statutes enacted by Congress, as agency regulations pursuant to authority from a statute, or as an ICE policy directive, also known as an “internal memo.” Of course, each type of reform suffers different limitations and challenges. ICE policies involve a high level of discretion by individual detention centers and the agency’s policies and procedures are primarily subject to only internal oversight to ensure their compliance.¹²⁰ In addition, since they are promulgated as regulations by the administrative agency or as internal policy memos, they do not go through the lengthy legislative process and are easy to change quickly. The history of ICE policies for detaining pregnant women evidences this important limitation.¹²¹ To pass legislation through Congress, of course, takes a significant amount of time. Additionally, it can be difficult to obtain support that is widespread enough to ensure federal statutes take effect, especially for immigration practices, an area of law often considered controversial.

Although this note proposes potential solutions aimed at the federal government, state legislatures and detention centers could also choose to adopt similar policies. This could provide additional benefits, such as the ability to gain local support, community input, more control over enforcement using state police power and other state agencies, and potentially a higher likelihood of legislative success than might be achieved at the federal level.

This section begins by proposing narrow solutions targeted to the first two of the three areas of concern described above. While any of these narrow solutions would be great places to begin reform, more expansive reform will be necessary to ensure lasting federal accountability and thorough protection for detained women. To address this recognition, the section concludes with more broad and comprehensive solutions that would require more work, but likely result in longer-lasting increased levels of safety for detained women and accountability for the federal government.

A. TARGETED SOLUTIONS TO SPECIFIC CONCERNS

1. Detention of Pregnant Women

ICE should begin by overturning the Trump-era policy of generally detaining pregnant women. This would hopefully reverse the 35% increase in the number of pregnant women detained when the Trump-era policy was

120. *Oversight of Detention Facilities: Hearing Before the Subcomm. on Oversight, Mgmt., & Accountability*, 116th Cong. (2019) (statement of Tae Johnson, Assistant Dir. for Custody Mgmt., Enf’t and Removal Operations, U.S. Immigr. and Customs Enf’t and U.S. Dep’t of Homeland Sec.).

121. See, e.g., ICE DIRECTIVE 11032.3, *supra* note 43.

enacted.¹²² ICE should return to detaining only those pregnant migrants who pose a particular identified threat, such as those with a previous criminal record. This would provide the most humane and fair balance between ensuring that immigrants who pose potential safety risks to the community are detained while awaiting their hearings or deportation and ensuring that pregnant women who do not pose such risks are able to enjoy a safe and healthy pregnancies. Recall that pregnant women at all stages require regular medical care to ensure a pregnancy that is safe for themselves and their babies.¹²³ In addition, because of the extensive care required during the third trimester of a pregnancy, ICE should abstain from detaining any pregnant woman in her third trimester unless she has been previously convicted of a violent felony.¹²⁴

2. Sterilizations of Detained Women

When the California prison system addressed the similar issue of forced sterilizations in its facilities, the state enacted a law that made the procedure a crime to commit in state prisons.¹²⁵ California enacted dramatic changes in the laws that govern its prison systems in large part due to the testimony of Kelli Dillon, a brave 24-year-old woman who experienced severe symptoms following a procedure completed while she served a sentence at Central California Women's Facility.¹²⁶ She had previously told the doctor that she wanted to have children, and when the doctor claimed he "removed some cysts," she asked afterwards whether she would be able to conceive children.¹²⁷ He replied, "I don't see why not," despite having removed her ovaries and part of her fallopian tubes, making it impossible for her to conceive.¹²⁸ After Dillon eventually learned from her attorney that the doctor's statement was not true, based on the medical records from the procedure, she stated, "I had been intentionally sterilized, and I have been lied to."¹²⁹

Now, the sterilization of an involuntarily detained or confined individual under any civil or criminal statute in California is generally prohibited.¹³⁰ Specifically, any method of "rendering an individual permanently incapable of reproducing, is prohibited except in" two

122. O'Connor, *supra* note 46.

123. *Prenatal care*, *supra* note 37.

124. See Mayo Clinic Staff, *supra* note 38.

125. Ko Bragg, 'Belly of the Beast' Spotlights Forced Sterilizations in California Prisons, THE 19TH (Austin) (Oct. 15, 2020), <https://19thnews.org/2020/10/belly-of-the-beast-forced-sterilizations-california-prisons/>.

126. *Id.*

127. *Id.* Due to her doctor's dishonesty, Dillon did not discover that her ovaries and fallopian tubes had been removed until her attorney, Cynthia Chandler, revealed Dillon's medical records during a legal visit with her in prison, *id.*

128. *Id.*

129. *Id.* (emphasis added).

130. CAL. PENAL CODE § 3440(a) (Deering 2021).

enumerated circumstances.¹³¹ The first is when the procedure is required to save the individual's life in an emergency medical situation.¹³² To satisfy the second exception, the procedure must be medically necessary to treat a diagnosed condition and satisfy three additional requirements: (1) less invasive measures do not exist, have been refused by the individual, or were attempted and deemed unsuccessful by the individual; (2) a second physician who is not employed by the department overseeing the individual's confinement consults with the patient in-person and confirms the need for surgical sterilization; and (3) the patient gives consent after being "made aware of the full and permanent impact the procedure will have on his or her reproductive capacity, that future medical treatment while [detained] will not be withheld should the individual refuse consent to the procedure, and its side effects."¹³³

Since this law applies to state prisons and jails,¹³⁴ it does not provide any protection for detainees in any immigration context, even in California. Requiring this type of standard procedure in detention centers would undoubtedly help to prevent many undesired sterilizations of migrant women. The California law further provides that if a compliant sterilization occurs, psychological consultations are required before and after.¹³⁵ The federal government could model their law after the California law and simply amend it to extend to immigration detainees. This would show support for the women who have been sterilized while detained in immigration detention centers and would take a huge leap towards preventing such procedures in the future. Their failure to do so represents a disregard for the basic human rights of migrant women to receive safe and non-coercive medical care and a lack of respect for their choice to conceive a child and create a family.

B. COMPREHENSIVE, LONG-TERM SOLUTIONS

The simplest, and perhaps most obvious way for the federal government to prevent women from receiving inadequate medical care in detention facilities would be to detain fewer women. By detaining fewer women altogether, the government would completely avoid liability for any physicians who fail to provide legally adequate care. It could also make physician discrimination against migrants less likely to occur because physicians would not be made aware of their patients' immigration status by, for example, seeing them arrive from detention facilities. It would help

131. CAL. PENAL CODE § 3440(b) (Deering 2021).

132. CAL. PENAL CODE § 3440(b)(1) (Deering 2021).

133. CAL. PENAL CODE § 3440(b)(2) (Deering 2021) (emphasis added).

134. CAL. PENAL CODE § 3440(a) (Deering 2021).

135. CAL. PENAL CODE § 3440(c) (Deering 2021).

allow pregnant women to safely obtain the frequent medical care that they require.¹³⁶

The federal government could also allow oversight of gynecological care provided to women being held in detention centers by HHS, instead of ICE. This federal agency would undoubtedly be better equipped to deal with medical concerns—its area of expertise—than ICE. This could also help to ensure that the goals for providing medical care (i.e., the health of the patient and, if pregnant, her baby) are prioritized over the politicized or personalized goals of individuals who wish to hurt detainees or make their experiences more difficult. It would likely provide one additional layer of protection for women who are in a vulnerable position and require medical care while detained.

In addition, the federal government should mandate periodic audits of the records of detention facilities and their providers to ensure their compliance with informed consent, abortion laws, and adopted procedures to prevent unwanted operations with reproductive and fertility consequences, such as hysterectomies. Perhaps most importantly, the government must create effective enforcement mechanisms for laws already in place and any new standards it enacts. These should include, at a minimum, reprimand procedures for ICE officers, ICE centers, state detention centers, and other facilities that fail to uphold the required standards for ensuring the proper medical care and treatment of women in detention. Without effective enforcement mechanisms, lack of meaningful oversight will continue to permit the abuse of power over vulnerable migrant women who need protection the most from mistreatment or inadequate medical care.

136. *Prenatal care*, *supra* note 37.