Borders, Laborers, and Racialized Medicalization

Mexican Immigration and US Public Health Practices in the 20th Century

Throughout the 20th century, US public health and immigration policies intersected with and informed one another in the country’s response to Mexican immigration. Three historical episodes illustrate how perceived racial differences influenced disease diagnosis: a 1916 typhus outbreak, the mid-century Bracero Program, and medical deportations that are taking place today. Disease, or just the threat of it, marked Mexicans as foreign, just as much as phenotype, native language, accent, or clothing. A focus on race rendered other factors and structures, such as poor working conditions or structural inequities in health care, invisible. This attitude had long-term effects on immigration policy, as well as on how Mexicans were received in the United States. (Am J Public Health. 2011;101:1024–1031. doi:10.2105/AJPH.2010.300056)

US IMMIGRATION POLICY WAS fairly open until the end of the 19th century, because immigrant labor was needed to help build and settle the expanding country. Federal restrictions on immigration did not appear until 1891, when Congress passed the first comprehensive immigration law. The law allowed immigrants to be barred from the United States for various reasons, ranging from being convicted of a crime to being considered likely to become a public charge, but many involved standards of fitness. Anyone considered “feebleminded,” “insane,” or likely to spread a “dangerous and loathsome contagious disease” was barred from the United States. An immigrant who was allowed entry into the United States but later fell ill and became a public charge (or even was thought likely to become a public charge) faced the possibility of deportation.¹ During the early 20th century, as public health as a field and profession became more established, it increasingly influenced immigration policy.

At the same time that US immigration and public health
policies were becoming more intertwined, Mexican immigration to the United States began to increase. From 1900 to 1930, the Mexican population in the United States more than doubled every 10 years. By 1930, an estimated 1.5 million Mexicans and Mexican Americans lived in the United States. Most Mexicans arrived as low-paid laborers who worked mainly in industries such as agriculture and railroad building. Nativists denounced Mexican immigrants as unable to assimilate, less intelligent than White Americans, and “for the most part, Indian” and therefore racially inferior. Increasingly, these stereotypes took the form of negative medicalized representations, giving rise to significant ramifications for immigration policy and securing the nation’s borders. Public health standards based on perceived racial difference influenced both the treatment and perceptions of Mexican immigrants not just at the time they crossed the border, but long after they settled in the United States.

MEDICALIZED BORDERS IN THE NATION’S INTERNAL BORDERLANDS

Medicalized representations of Mexicans in the United States can be traced back to when what is now the US Southwest was still a part of Mexico. The ideology of Manifest Destiny gained popularity during the Mexican–American War (1846–1848) and provided justification for US expansionism. Dedicated believers in Manifest Destiny were compelled to portray White Americans as superior to Mexicans and Native Americans. Expansionists argued that after the US takeover, Mexicans and Native Americans would eventually disappear in the Southwest because these peoples were not as biologically fit as Americans. Mexican immigration to the United States increased in the second decade of the 20th century, driven by the need for laborers, particularly in the Southwest’s burgeoning agricultural industry. The demand for laborers was conveniently met by refugees fleeing the ravages of the Mexican Revolution. Mexicans were ideal migrant laborers: sojourner males who traveled to secure work but would eventually return home. Such workers required no capital or social investment—they needed little more than a willing employer and transient housing.

Although immigration laws did not severely restrict Mexican immigration at this time, public health standards helped shape attitudes and regulations directed at this new laboring class. As Fairchild found in a study of the nation’s borders, medical inspectors indoctrinated incoming immigrants by demonstrating to them the social and industrial norms needed to succeed as workers in the United States. Thus, far from excluding workers, health inspectors could shape immigrants into an acceptable laboring class. In the borderlands, however, such practices could also stigmatize Mexicans.

Before the enactment of restrictive laws such as the 1917 Immigration Act, which imposed a head tax and literacy test, medical screenings already regulated Mexican immigration. Mexicans underwent intrusive, humiliating, and harmful baths and physical examinations at the hands of the US Public Health Service (USPHS) at the US–Mexico border beginning in 1916. The typhus cases in Los Angeles preceded a quarantine on the US–Mexico border in Texas the next year, also spurred by a handful of cases. Nonetheless, as Stern, writing about the Texas quarantine, argues, these practices “fostered scientific and popular prejudices about the biological inferiority of Mexicans.” These medically driven policies had far-reaching social and political effects.

When a Mexican laborer at a Southern Pacific Railroad camp near Palmdale (20 miles north of Los Angeles) came down with typhus in June 1916, health officials were alarmed. Typhus is an infectious disease caused by the monthly health bulletin.

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Far left. Mexican immigrants were depicted as “[t]he type of people who are bringing typhus and other diseases into California from Mexico” by the monthly health bulletin.

rickettsia (a bacterialike microorganism) and transmitted to humans through lice and tick bites. Although not contagious, in the right conditions (overcrowding, lack of facilities for bathing and washing clothes, poor sanitation), typhus can rapidly become an epidemic. Ultimately, 26 people contracted the disease (including 22 Mexican railroad workers) over a 5-month period from June to October 1916. The outbreak killed 5 people, all of them Mexican.

Public health officials at the county, state, and national levels soon became involved. County measures to contain the outbreak involved hygiene, sanitation, and education campaigns, all aimed exclusively at Mexicans. Howard D. King of New Orleans warned, “Every individual hailing from Mexico should be regarded as potentially pathogenic.” The stigma of the typhus outbreaks marked every area where Mexicans lived as needing inspection. In 30 railroad camps in California, health officials were particularly aggressive; they used cyanide gas to destroy lice, ticks, and other pests.

The California State Board of Health pressured railroad employers to play a role in containing the typhus outbreak. Officials drew up an eight-point list of regulations, printed in both English and Spanish, and labor recruiters distributed the list to the various railroad camps. The regulations applied to every man, woman, and child living in the camps, not just to laborers. All of the regulations focused on improving personal hygiene; not one addressed the inferior living conditions in the camps.

Mexican laborers expressed frustration over the attention paid to their individual actions, with no mention of structural problems in the camps, such as a dearth of toilets and bathing facilities. This frustration is clear in a formal letter of complaint sent to the Mexican consul in Los Angeles by a group of Mexicans who lived in a desert camp about 140 miles east of the city. The men, angry over the crudeness and impracticality of the anti-typhus procedures and the overt racism of the regulations, submitted their complaint just two weeks after the state board issued the regulations:

Dear Sir:

Due to the difficult circumstances we find ourselves in this foreign country, we look to you asking for help in this case. We are enclosing a copy of the severe law that the railroad line has imposed on us. We work on the track, which we do not see as a just thing, but only offensive and humiliating. When we crossed the border into this country, the health inspector inspected us. If the railroad line needs or wants to take such precautions it is not necessary that they treat us in this manner. For this, they would need health inspectors who assisted every individual with medical care and give us 2 rooms to live, one to sleep in and one to cook in, and also to pay a fair wage to obtain a change of clothes and a bar of soap. This wage they set is not enough for the nourishment of one person. Health comes from this and these precautions are the basis for achieving sanitation. Health we have. What we need is liberty and the opportunity to achieve it. We need a bathroom in each section of camp and that the toilets that are now next to the sleeping quarters be moved. Many times their bad smell has prevented us from even eating our simple meal. Furthermore, we can disclose many other details which compromise our good health and personal hygiene.

With no further ado, we remain yours, graciously and devotedly, your attentive and faithful servants. We thank you in advance for what you may be able to do for us.

Felipe Vaiz, José Martinez, Felipe Martinez, Adolfo Robles, Alejandro Gómez, Alberto Esquivel.

Drawing on an alternative epistemology, the men explained that their living conditions resulted from systemic inequality, not from ingrained cultural habit. Unlike the state and county officials who crafted reports that avoided charging the railroad companies with any responsibility for the presence of disease and dirt in the camps, the workers did not hesitate to assign blame where it belonged. Health officials focused their efforts to stem the typhus outbreaks on remedying Mexicans’ “unclean habits,” but the letter writers pointed out the obvious: the unsanitary living conditions that so disturbed health officials were created and maintained by the railroad employers.

By failing to treat typhus as a threat to the public at large, officials constructed the disease as uniquely Mexican. This preference for making race the organizing principle for understanding typhus also transformed Mexicans from unfortunate victims of a serious disease into active transmitters of deadly germs, thus adding a medicalized dimension to existing nativism. Armored by their presumed scientific objectivity, health officials gave wide circulation to constructed categories of Mexicans as unclean, ignorant of basic hygiene practices, and unwitting hosts for communicable diseases. These images were embedded in medical and media narratives and in public policy.
Visual depictions of Mexicans effectively linked them with disease. In October 1916, for example, the cover of the *California State Board of Health Monthly Bulletin* was emblazoned with a photograph of Mexican men, women, and children who lived in the railroad camps. The caption, “The type of people who are bringing typhus and other diseases into California from Mexico,” ensured that not even the most naive of readers could miss the point.13 Used in this way, the word “type” reduced all Mexican immigrants to a static archetype. Race, not symptoms, became shorthand for disease carrier.14 Although the potential typhus epidemic was contained, it spurred widespread changes in immigration inspection procedures. General inspections at the border increased, even for laborers who crossed daily. The Los Angeles County Health Department received assurances that in the future, dissections at the El Paso border would be performed by USPHS staff. Indeed, the USPHS planned to establish multiple inspection stations along the Texas border—in El Paso, Eagle Pass, Laredo, and Brownsville—a move county officials applauded.15 Mandatory inspections continued into the late 1920s, further demonstrating the extent to which Mexican immigrants and disease had become conflated.16

**BRACERO PROGRAM AND HEALTH**

The idea that Mexicans were likely to spread disease continued to shape immigration policies in the following decades, notably in the Bracero Program. In 1942, the United States and Mexico collaborated in creating this guest worker arrangement, which operated until 1964. The Bracero Program brought four million Mexican men to the United States to work in agriculture and other industries such as railroads to fill World War II labor shortages. The physically rigorous nature of the work the US government was recruiting workers for necessitated assurances that they would be productive and that they posed no public health threat. This recruitment took place in the wake of deportation programs carried out just a few years earlier. During the Great Depression, everyday citizens and government officials alike scapegoated Mexican immigrants as both drains on the US economy and cultural outsiders. These attitudes led to deportations (voluntary and involuntary) that sent an estimated 1.6 million Mexicans back to their homeland. Although the majority of deportations had ended by 1935, Mexicans who sought medical care at public institutions still risked deportation. The coexistence of the deportations and guest worker program illustrates the pliability of a racial logic that could view Mexicans as liabilities and resources simultaneously.17 Scholars have informed our understanding of the Bracero Program by looking at the complexity of the government policy and administration that drove the program.18 More recently, researchers have shown how the workers themselves exhibited agency as they negotiated this program and how the program affected not just them, but also their families, bringing a much-needed gender analysis to this area of study.19 These recent scholarly works, along with other sources, such as newspaper articles and previously untapped oral interviews, combine to support the conclusion that health policies that were central to the Bracero Program continued to regard Mexicans as health threats rather than critically examining systemic inequalities created and maintained by the Bracero Program. These policies, overseen and sanctioned by the federal government, signaled a new era in medical racial profiling, thus offering a new framework for disciplining labor.

Braceros were recruited in Mexico and underwent health screenings in both Mexico and the United States. In Mexico, personnel from the USPHS, along with the War Manpower Commission and the Farm Security Administration, oversaw the contracting of workers, in collaboration with Mexican officials. Mexicans seeking to participate in the program were required to pass a physical examination by both US and Mexican public health doctors in accordance with US immigration policies and railroad company regulations. US public health officials used standards developed by the US military for conducting medical screenings. Officials required every prospective bracero to undergo a physical examination, with chest x-rays to check for tuberculosis, serological tests to check for venereal disease, psychological profiling, and a chemical bath. They tested applicants to see whether they were capable of the arduous labor expected of them, checking their hands for calluses and their bodies for scars. Inspectors could interpret fresh scars as evidence of injury or pain, thus potentially disqualifying the applicant.20

Mexicans found the examinations tiring and humiliating. In her research, historian Ana Rosas found that men could wait
anywhere between 6 and 10 hours to be examined. Physicians directed the men into an examination room that held as many as 40 men at a time, where they had to undress and undergo an examination the doctors conducted in English. Scholar Barbara Driscoll notes that recruits complained to Mexican officials that USPHS officials were harassing them. Applicants who passed this examination and were accepted to the program found that their trials were not over: they underwent yet another compulsory physical examination when they arrived in the US bracero camps.

Mexican men did their best to retain their dignity through this process. Historian Deborah Cohen interviewed men applying to the Bracero Program and found that Mexican men recast parts of the exams in a positive light. The men wanted to be seen as strong, healthy, and hard working, so they willingly extended their calloused hands to inspectors as evidence of these qualities. This image was important to them not just as potential participants in the Bracero Program, but as male breadwinners for their family and as part of their own sense of masculinity. Applicants also recalled trying to subvert the x-ray examination by drinking large quantities of milk beforehand. They did this not because they had something to hide but because they feared the physicians might find some small imperfection that could be used to disqualify them from the program.

Despite the perception that Mexicans posed a public health threat, the War Manpower Commission, created during World War II to balance the labor needs of agriculture, industry, and the armed forces, was not always willing to fully fund the USPHS physicians’ work. When the USPHS moved from its original location in Mexico City to San Luis Potosi, the employees asked to take the x-ray equipment with them. The War Manpower Commission denied permission on the premise that x-rays were too costly. In 1945, however, a railroad company in eastern Florida complained that a bracero in its employ had an active case of tuberculosis. After this complaint, the USPHS received permission to move the x-ray equipment to its new office, although the head of the War Manpower Commission refused to purchase any more medical equipment.

In the United States, contracted workers underwent a second inspection at USPHS processing centers that duplicated the procedures they experienced in Mexico. USPHS centers in and around El Paso, Texas, the largest port of entry into the United States from Mexico, processed many of the braceros. Often the braceros were transported in cattle cars. Personnel routinely processed 800 to 1600 braceros at a time and in some cases, more than 3100. Carlos Cordella, a processing employee, described how braceros were asked to strip and then were sprayed with a white powder on their hair, face, and “lower area,” a procedure that embarrassed them. Some tolerated the situation with humor, declaring, “I guess we’re gringos now.”

Many other problems arose in the US inspections. Pedro Ortega, MD, reported that US doctors sold the x-ray films of men who had passed the physical exam to braceros who worried about passing. He also reported that doctors occasionally gave penicillin to braceros with the goal of keeping them in good health for six months, the length of their contract.

Although health standards were ostensibly important selection criteria, once braceros were hired, the employers did not adhere to the same standards in providing safe working and living conditions. According to a report from California’s State Senate Fact Finding Committee on Labor and Welfare, inadequate health and accident insurance and employee housing ranked among the laborers’ most frequent complaints.

In one case in Santa Barbara, California, in 1963, the US Department of Labor was called into a work camp to conduct a special investigation after receiving reports that “wretched conditions existed in the camps.” The laborers charged that they had been threatened with return to Mexico if they filed any complaints. Braceros with health problems claimed that they received “unsympathetic treatment from camp doctors.” They also complained that they were not given enough to eat and were often served spoiled meat and that their wages were not paid in full. It is striking that concerns about access to health care and the standard of living persisted throughout the Bracero Program’s 22-year existence. It is also striking that these concerns involved a government program, carried out by the very same government that was enacting laws and policies dedicated to eradicating the diseases that were spawned by the conditions in which the workers were forced to live.

In its final years, the Bracero Program faced a congressional opponent in Representative Edward Roybal. Representative Roybal began his career as a public educator with the California
MEDICAL DEPORTATIONS

The consistent representation of Mexicans as disease carriers unworthy of social membership in US society led to the conclusion that they were unworthy recipients of publicly funded health care. This philosophy is exemplified by the frightening modern-day practice of patient deportation by hospitals. Some hospitals, without prompting from the federal government, are taking it upon themselves to return patients to their home countries if they are undocumented, without insurance, and in need of long-term care. This occurs because, by law, hospitals that accept Medicare are required to secure continuing care before discharging Medicare patients. Except in California and New York, Medicare does not pay for long-term care for undocumented patients, so hospitals undertake a large financial burden when they accept such patients.

Hospital administrators who deport patients do not necessarily secure health care in the patients’ home country. One attorney, whose practice specializes in these cases, objected,

If somebody has a serious illness and needs continuing care, a hospital can’t simply discharge them onto the street, much less put them onto a plane.33

These hospital-initiated deportations shine a light on how deportations are being performed today outside the purview of Homeland Security.

In today’s climate, in which many view Latino immigrants as an economic, cultural, and social threat, it is not surprising that Latino immigrants are often the targets of medical deportations. Although the deportation of immigrants by hospitals is not a practice originated to regulate immigration from Latin America, but rather as a response to the perceived burden of patients from other countries who are unable to pay for their care, these deportations are nonetheless undergirded by the same racial logic that led to public health screenings during the 1916 typhus outbreak and the Bracero Program, in which immigrant Mexicans were consistently characterized as a problem for or threat to US society. In addition, these deportations are connected to other contemporary medical practices and acts that stigmatize Mexicans, such as the passage of California Proposition 187 in 1994, which sought to withhold public services from undocumented immigrants.24

Anthropologist Leo Chavez provides a fascinating look at the contemporary categorization of Latinos as threats through medical discourse in his examination of immigrants as organ transplant recipients.35 Similarly, anthropologist Jonathan Inda examines how immigrants are constructed as incapable of governing themselves through his research on changes in immigration and welfare policy, such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.36

Hospital deportations suggest that little has changed in the workplace for immigrants since the early 20th century. Low-wage, low-skilled immigrants routinely perform the most dangerous jobs, yet are not provided health care as part of their employment and earn too little to purchase their own health insurance. According to a recent special issue of the American Journal of Industrial Medicine on occupational health disparities,

Immigrant Latino workers have fatal traumatic injury rates that are one-third higher than U.S. workers overall. Hispanic workers also experience high rates of non-fatal, lost-work injured and prolonged recovery times. Studies show that such workers commonly work in the more dangerous jobs, receive little training, and are exploited by employers.7,37,38

Focusing on the cost of providing long-term care to injured immigrants reinforces the image of Latinos as a threat and potential burden, obviating the need to examine the systemic inequalities that place Latinos in this position. Journalist Deborah Sontag has documented cases of deportations resulting from what she terms a
“collision of two deeply flawed American systems, immigration and health care.” She writes about Luis Alberto Jimenez, an undocumented Guatemalan immigrant, who was working as a gardener in Florida when he became the victim of a drunk driver in an auto accident. Uninsured, Jimenez owed hospital and rehabilitation bills of $1.5 million. The hospital, Martin Memorial, obtained a court order and “forced” him to return to his home country, according to a hospital administrator, although an appeal was pending. The hospital did not notify Jimenez’s family of the deportation. In Phoenix, Arizona, as a Mexican patient lay in a coma, hospital personnel, without the family’s permission, took her fingerprints to begin deportation proceedings. Not all deported immigrants are undocumented. Some hospitals routinely return both documented and undocumented immigrants simply because they are uninsured. A Tucson, Arizona, hospital attempted to send a sick baby, born in the United States to an undocumented Mexican couple, to the parents’ home country. The process was stopped only after legal intervention.

Because these deportations are not part of an official government program, no official statistics exist on how many immigrants have been affected, but the increasing prevalence of examples suggests a trend. St. Joseph’s Hospital, in Phoenix, which has a large Mexican immigrant population, has reported deporting 96 immigrants. Since 2007, 10 immigrants have been returned to Honduras from Chicago, Illinois, hospitals. In San Diego, California, the Mexican consulate reported 87 medical cases, most of which ended in deportation.

The Guatemalan foreign ministry listed 53 deportations by US hospitals from 2003 to 2008. In addition, medicalized repatriation programs have been privatized as companies have developed to provide the services usually undertaken by federal immigration authorities. One such company is MexCare, located in San Diego, which bills itself as “an alternative choice for the care of the unfunded Latin American national.” MexCare works with “any hospital seeking to defray un-reimbursed medical expenses” to transport patients to their home country. MexCare emphasizes that it only transports patients when they have received the authorization of the patient or family. By contrast, Steven Larson, MD, an expert on migrant health and an emergency room physician, considers repatriation a “death sentence” in some cases.

Although transnational patient dumping is a recent phenomenon, it nonetheless follows patterns established throughout the 20th century, in which medical discourse is used to distinguish desirable and undesirable members of society. The emergence of private companies such as MexCare is symptomatic of a neoliberal era in which private companies take over activities once performed by public entities. The seeming ease with which a private company can transport a patient in critical condition from Chicago to Honduras is also a feature of the era of globalization. Yet the same racial logic that gave rise to harmful policies and practices in the typhus epidemic and Bracero Program continues to affect Hispanics and other Latin American immigrants.

**CONCLUSIONS**

How a problem is defined shapes the solution. Negative representations of Mexicans as disease carriers and health burdens shaped the programs, policies, and practices of immigration and health agencies. Many documented cases illustrate the medicalization of the Mexican immigrant historically. The reaction to typhus outbreaks in the early 20th century and the development of health policy standards in the Bracero Program revolved around representations of Mexicans as a threat to public health. Race served as an interpretive framework for explaining the typhus outbreaks and for developing a double-screening policy for braceros entering the United States and thus precluded any need to ameliorate the living conditions of workers once they had settled in the United States. Such reasoning, firmly established, obviated the need for a deeper investigation into the systemic inequality that fostered the inferior health and living conditions of Mexican laborers. Because medical discourse has the power to naturalize racial categories, it has also in some cases naturalized societal inequalities.

The fact that medical discourse had demonstrable influence on perceptions and consequently on the treatment of Mexican immigrants does not mean that all programs failed to implement changes that improved the public’s overall health and welfare. To the contrary, public health agencies and practitioners have carried out many genuinely successful efforts, from reducing infant mortality rates to maintaining pure water supplies. Nonetheless, the power of public health discourse to affect perceptions of race and to contribute to inequalities continues in the 21st century.

Latinos who face deportation by US hospitals today, like their counterparts before them, are perceived as unworthy of US aid. Hospital deportations continue to obscure the global structure of inequality: people immigrate to develop nations in search of work, the destination countries benefit from the cheap labor without providing the necessities of a sustainable community, and then the immigrants become scapegoats for the problems that inevitably arise. The situation today did not arise spontaneously but rather flows from the long history of negative representations of Mexicans as outsiders who are unfit to be citizens.
Louse-borne Typhus is the only rickettsial disease which can cause explosive epidemics in humans." See Epidemic Louse-Borne Typhus.

9. In addition to the 22 Mexican railroad workers, 1 person in the city of Los Angeles contracted typhus, 2 people in the county (but not from the railroad camps) were affected, and no details are available regarding the 1 remaining case. There were also outbreaks in areas outside the county: 7 cases in Banning (Riverside County), 1 in Livermore (Alameda County), 1 in Bakersfield (Kern County), and 3 in Tulare (Tulare County). Califonia State Board of Monthly Bulletin (Sacramento: State Board of Health), June–December 1916.


11. Los Angeles County Health Department, "Quarterly Health Report, 7/1–9/30/16," Records, Los Angeles County Department of Health Services Library, Main Office, Los Angeles (DHS). Dehousing procedures at this time typically involved routine baths, laundering clothes, and cleaning living quarters. Use of cyanide gas was not common because of the effects chemical gases could have on the central nervous system. In Prussia, however, the military used hydrocyanic acid to fumigate dungs and railway carriages. The key ingredient was sodium cyanide, and the substance also contained sulphuric acid and water. See P. J. Weindling, Epidemics and Genocide in Eastern Europe (Oxford and New York: Oxford University Press, 2000), esp. chap. 4, "The First World War and Combating Lice."

12. F. Vázquez. et al. to Mexican consul, October 17, 1916, Foreign Consulate Records for Los Angeles, Archives Secretaria de Relaciones Exteriores [Secretary of Foreign Relations], Mexico City.


20. B. A. Driscoll, The Tracks North: The Railroad Bracero Program of World War II (Austin: Center for Mexican Americans, University of Texas at Austin, 1999), 53, 73, 91; Cohen, "Masculine Sweat, Stoop-Labor Modernity."


22. Driscoll, Tracks North, 93.


25. Driscoll, Tracks North, 93–94.


27. S. Sánchez, oral interview, Bracero History Archive.

28. C. Corella, oral interview, Bracero History Archive.

29. P. Ortega, oral interview, Bracero History Archive.


34. California Proposition 187 was approved via referendum by California voters in 1994 to prevent undocumented immigrants from receiving public benefits or services, including health care and education. Legal challenges prevented it from being implemented. Ostensibly, Proposition 187 was directed at all undocumented immigrants, but within California’s political and cultural climate, it was understood that the proposition’s primary target was Mexicans. P. Hondagneu-Sotelo, "Women and Children First: New Directions in Anti-Immigrant Politics," Socialist Review 25, no. 1 (1995): 169–190.


40. Sontag, "Deported by U.S. Hospitals."

41. Ibid.


43. Sontag, "Deported by U.S. Hospitals.

44. MexCare.