

Public charge, legal estrangement, and renegotiating situational trust in the US healthcare safety net

Meredith Van Natta

Department of Sociology, University of California
Merced, Merced, California, USA

Correspondence

Meredith Van Natta, Department of Sociology,
University of California Merced, Merced,
California, USA.

Email: mvannatta@ucmerced.edu

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Abstract

US immigration law increasingly excludes many immigrants materially and symbolically from vital safety-net resources. Existing scholarship has emphasized the public charge rule as a key mechanism for enacting these exclusionary trends, but less is known about how recent public charge uncertainty has shaped how noncitizens and healthcare workers negotiate safety-net resources. Drawing on ethnographic observations and interviews with 80 safety-net workers and patients in three US states from 2015 to 2020, I argue that intensifying anti-immigrant rhetoric surrounding public charge has extended a sense of surveillance into clinical spaces in previously unexamined ways. Drawing on theories of medical legal violence, system avoidance, and legal estrangement, I demonstrate how these dynamics undermined immigrants' health chances and compromised clinic workers' efforts to facilitate care. I also reveal how participants responded to this insinuation of legal violence in healthcare spaces by promoting situational trust in specific procedures and institutions.

INTRODUCTION

As anti-immigrant politics have accelerated in recent decades, many noncitizens and mixed-status families increasingly avoid resources for which they are eligible based on the perception that doing otherwise might subject them to immigration enforcement penalties (Ku & Matani, 2001; Vargas & Pirog, 2016; Watson, 2014). A prime example of this is the chilling effect of the “public charge” rule expansion that went into effect early in the COVID-19 pandemic (Barofsky et al., 2020; Capps et al., 2020; Haley et al., 2020; Makhoul & Sandhu, 2020). The public charge rule (87 FR 55472), which makes certain noncitizens ineligible for entry or permanent residence based on their use of particular public benefits (currently classified as cash assistance and/or institutionalization in a long-term care facility), exemplifies how immigration laws increasingly codify the stratified deservingness of immigrants who are racialized as non-white in the United States (Fox, 2010; Neubeck & Cazenave, 2001). Recent controversies over this rule have drawn national attention, yet little is known about how anti-immigrant rhetoric has shaped healthcare negotiations under changing political conditions.

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In this article, I draw on ethnographic observations and interviews with 80 safety-net clinic workers and patients in three US states to reveal how uncertainty around policies such as the public charge rule further extends the punitive functions of the state into the supposedly more beneficent sphere of the social safety net. This, in turn, enhances socially targeted groups' distrust of and alienation from legal procedures and institutions—or their “legal cynicism” (Sampson & Bartusch, 1998) and “legal estrangement” (Bell, 2017), respectively—and extends these features into clinical spaces. Additionally, I show that in response to political uncertainty and restrictive laws that participants perceived as potential threats to health and safety, patients and clinic workers sought opportunities to reassert control through “situational trust” (Bell, 2016) in specific institutional practices. I argue that uncertain yet antagonistic political conditions exacerbated immigrant criminalization through a sense of intensified surveillance while sowing confusion over policy implementation among differentially situated participants. These dynamics extended legal estrangement into healthcare spaces while also sparking strategies to negotiate situational trust in specific clinic procedures and federal laws that participants perceived as protective rather than politically volatile.

Public charge and immigrant criminalization

“Public charge” first became codified through the Immigration Act of 1882, which barred admission to the United States of any “convict, lunatic, idiot, or any person unable to take care of himself or herself without becoming a [public] charge” (Immigration Act of 1882, 22 Stat. 214). Like the Chinese Exclusion Act of the same year, such laws aimed to construct an ideal citizen and, in turn, classify and exclude those who were deemed unworthy of that ideal (Menjívar, 2021). Subsequent laws established and upheld national origin quotas for immigrants coming from beyond the Western Hemisphere (Immigration and Nationality Act of 1924 and 1952) and declared that “any alien [...] likely at any time to become a public charge” may be considered either inadmissible or removed if they receive public benefits within their first 5 years in the United States (8 U.S.C. §1182, 1260).

By the 1990s, federal immigration and public benefits laws amplified this racialized punitive legal architecture (Stuart et al., 2015). In 1996 alone, Congress passed the Immigration Reform and Immigrant Responsibility Act (IIRIRA), the Antiterrorism and Effective Death Penalty Act (AEDPA), and the Personal Responsibility and Work Opportunity Reauthorization Act (PRWORA). These laws escalated criminal penalties for what had previously been minor infractions (Abrego et al., 2017) and devolved immigration enforcement authority to state and local agencies through 287(g) agreements (8 U.S.C. §1357(g)).

Meanwhile PRWORA created the categories of “qualified alien” and “non-qualified alien” regarding noncitizens' public benefits eligibility (Viladrich, 2012). This law classified undocumented immigrants and lawful permanent residents living in the United States for less than 5 years as unqualified for many public benefits. This included full-scope Medicaid, a federally subsidized healthcare program for low-income individuals, and made only restricted (or “Emergency”) Medicaid available to income-eligible non-qualified noncitizens. In 1999, the Immigration and Naturalization Service issued guidance that included cash assistance, Supplemental Security Income (SSI), and publicly financed long-term care among “public charge” benefits. This guidance explicitly excluded the use of restricted Medicaid and several other non-cash benefits by those who were not classified as “qualified aliens” (64 FR 28689).

Following a leaked 2017 draft rule and amended proposed rule in 2018, the Trump administration published a final rule in 2019 that altered the 1999 guidance and expanded public charge criteria to include additional forms of Medicaid, the Supplemental Nutrition Assistance Program (“SNAP” or “food stamps”), and publicly subsidized housing programs (84 FR 41292). It also added language to consider noncitizens' receipt of one or more of these benefits “for more than 12 months in the aggregate within any 36-month period” (84 FR 41292, 41295). Importantly, while millions of noncitizens were not subject to this rule (and never had been), and while the actual public benefits encompassed within it were relatively narrow, the perception of severe consequences for any immigrant using any public benefits nevertheless exacerbated the rule's chilling effect on immigrant families (Capps et al., 2020).

Legal violence, cynicism, and estrangement

Due to a lack of clarity regarding both the parameters and legality of the final rule, public confusion continued after the changes went into effect on February 24, 2020, just as COVID-19 first proliferated in the United States. This emergency thus exacerbated the ongoing material harms of public charge and underscored what Menjívar and Abrego (2012) refer to as “legal violence.” This concept captures how immigration law increasingly intertwines with criminal law to criminalize immigrants—especially those from Latin America—whose everyday lives become permeated by this socially constructed illegality. And even as such immigration laws appear superficially race-neutral, they disproportionately harm immigrants from Latin American who are frequently racialized in the United States as non-white.

Previous scholarship has also demonstrated how increasingly aggressive federal immigration enforcement enables medical-legal bureaucracies to become potential tools for immigrant surveillance (Gómez Cervantes & Menjívar, 2020; Jimenez, 2021; Kline 2019; Van Natta, 2019). This medical legal violence insinuates anti-immigrant laws into health institutions in ways that disproportionately surveil and penalize immigrants of color as they seek health care, and—importantly—it also enrolls healthcare workers as either agents or targets of that violence. In this article, I examine how medical legal violence in turn enables “legal estrangement,” or “a marginal and ambivalent relationship with society, the law, and predominant social norms that emanates from institutional and legal failure” (Bell, 2017: 2083), to extend into clinical spaces in insidious ways.

Existing scholarship on legal estrangement (and its more individual, attitudinal component, “legal cynicism”) has focused primarily on the punitive arms of the state, including policing and immigration enforcement. Sampson and Bartusch (1998) proposed “legal cynicism” to describe how the “anomie” that Black people living in racially and economically marginalized Chicago neighborhoods felt toward the law was a product of concentrated, intersecting inequalities at the neighborhood level (Sampson & Bartusch, 1998: 778–9). Their research emphasized the need to consider the contextual factors of racially minoritized, economically disadvantaged communities in sowing distrust in the procedural legitimacy of the legal system instead of fixating on apparently pathological cultural or attitudinal orientations toward crime (Sampson & Bartusch, 1998: 780).

More recently, yet still within the empirical context of policing, Bell (2016) has approached legal cynicism through a situational lens that illuminates “how trust and distrust operate on a micro-level, situated within a broader cultural and structural milieu” (Bell, 2016: 317). These conditions generate specific strategies of police engagement that African American mothers in low-income housing communities employ alongside more generalized distrust of police. Bell goes beyond what she describes as the “attitudinal” orientation of legal cynicism to understand distrust more expansively as legal estrangement: “a cultural orientation about the law that emanates from collective symbolic and structural exclusion...” (Bell, 2017: 2100). She also describes how individuals who generally express legal cynicism and estrangement may enact “situational trust” through specific micro-strategies “that enable occasional proactive engagement with police” (Bell, 2016: 316). In this context, trust is not merely an individual subjective characteristic but also an intersubjective process that is “negotiated and deployed in emotionally charged moments between actors” (Bell, 2016: 338).

Existing scholarship has documented some of the consequences of this estrangement by examining how those who have experienced individual and/or collective contact with the criminal legal system often engage in “system avoidance” of a variety of surveilling institutions, including medical spaces (e.g., Goffman, 2009, 2014; Brayne, 2014; Seim, 2017). Goffman (2009, 2014) describes participants avoiding medical institutions despite serious injury to avoid law enforcement entanglements, but there is little discussion of healthcare institutions per se beyond suggesting that police presence may further deter people who are already “on the run” from seeking care (Goffman, 2009: 344). Brayne (2014), on the other hand, empirically tests how an individual’s legal cynicism might impact system avoidance across multiple institutions. While this work does not account for collective or vicarious legal estrangement, Brayne does find that an individual’s direct criminal legal system contact “is associated with higher odds of not obtaining medical care when individuals thought they

needed it” (Brayne, 2014: 379). In addition, at an organization level, Seim’s (2017) focus on ambulance crews’ position between nursing care and policing illustrates some of the contextual factors that enable the punitive arm of the state to pervade its more beneficent institutions. However, while this research reveals important tensions among street-level workers representing the “right” and “left” hand of the state (Seim, 2017: 459–60), there is less consideration for how healthcare personnel within medical institutions may also endure perceived and manifest criminalization themselves because of this tension.

Given the many parallels between policing and immigration enforcement, immigration scholars have also engaged the concepts of legal cynicism and legal estrangement among immigrant individuals and communities (e.g., Armenta & Rosales, 2019; Asad, 2023; Kirk et al., 2012; Ryo, 2015; Wong et al., 2021). Like Bell, these scholars often emphasize the ambivalence immigrant communities experience as they alternately fear and trust in legal procedures and institutions. Ramirez (2021), for example, examines how individuals’ vicarious experiences of immigration enforcement shape how they perceive the law’s relative (il)legitimacy in uneven ways that spill over onto US citizens. Similarly, within this context of direct and vicarious, individual and collective, institutional estrangements, Armenta and Sarabia (2020) focus specifically on healthcare negotiations in immigrant communities. They note that there has been limited research on how undocumented immigrants access health care despite numerous structural exclusions and emphasize the understudied role of nonmedical personnel in facilitating that care.

These insights from previous policing and immigration scholarship shed light onto how criminalization often reshapes interactions with healthcare institutions, but it is still unclear how both patients and healthcare workers in these clinical spaces respond to legal estrangement and engage in specific strategies to promote situational trust. In addition, while a growing body of research has explored legal estrangement among criminalized groups, less attention has been paid to service providers’ experiences of legal estrangement from their position within health and welfare institutions (e.g., Kline, 2019). The present article extends these areas of inquiry while also documenting strategies that variously situated participants engage in to exercise agency amid legal estrangement. In what follows, I address how recent political uncertainty has intensified legal violence and generated legal estrangement beyond legal institutions. I demonstrate how public confusion over federal immigration and health laws, coupled with anti-immigrant rhetoric and a sense of enhanced surveillance, impacted the healthcare negotiations of (1) immigrant patients and their families, and (2) various healthcare workers who were also constrained by immigration laws while facilitating care. By examining the aforementioned “chilling effects” through the lenses of medical legal violence (the cause or source of harms) and legal estrangement (the consequences of those harms), I illuminate participants’ efforts to foster situational trust and reassert a sense of control amid social disruption.

METHODS AND DATA

From 2015 to 2020, I conducted interviews and ethnographic observations in community clinics in three US states. Previous research (e.g., Varsanyi et al., 2012; Viladrich, 2012) documented the complex consequences of US federalism on public policy at the state and local level. As the boundaries between citizens and noncitizens were “brightened” following the immigration and welfare reforms of the 1990s and the 2010 Patient Protection and Affordable Care Act (ACA) (Marrow & Joseph, 2015), states and counties desiring more inclusive immigrant safety-net policies had to pursue them without federal funding. These contemporary developments suggest the possibility that “nested” immigrant reception contexts (Golash-Boza & Valdez, 2018) that either amplify or mitigate federal social policies may contribute to geographic variation in immigrants’ on-the-ground healthcare negotiations.

To explore these potential nuances, I selected clinical sites in states with distinct political landscapes. However, as anti-immigrant politics intensified, immigration law experts with whom I

consulted cautioned that my research might draw attention to immigrant-inclusive policies and jeopardize both those who sought and provided services. I therefore elected not to disclose state names and informed prospective participants that, in addition to using pseudonyms for people, I would also do so for the states and clinic sites where I conducted research. I thus refer to these states pseudonymously based on their respective state-level political party governance at the time of the research: politically progressive (“blue”), politically conservative (“red”), or mixed party leadership (“purple”). Each site may also be conceptualized through Young and Wallace’s (2019) framework of relative immigrant integration and criminalization: the blue state site represented a high integration, low criminalization context; the red state a high integration, high criminalization context; and the purple state a low integration, high criminalization context (Young & Wallace, 2019: 1174).

During the study period, I focused recruitment primarily within one county in each state. I relied on professional networks I developed through my previous work as a safety-net surgical case manager and certified healthcare interpreter alongside my academic research affiliations. Within each state/county, I selected clinics based on which were open to my presence as a researcher—a feature which varied depending on the timing and local politics. While I only observed one or two clinic sites in each area, snowball sampling enabled me to interview participants at affiliated institutions. I completed in-depth interviews with 80 participants across the three study sites. Of these, 34 were patients (33 Latinx immigrants and one US-born citizen in a mixed-status family), and 46 were employees/volunteers who worked at clinics and affiliated community organizations. I conducted the interviews in English, Spanish, and Portuguese. Table 1 includes details of the study sites and their respective participant and policy contexts. Interviews included questions about how participants came to the clinic (whether as a patient/family member or as a worker), specific situations in which they navigated safety-net health care services, and how they understood and engaged with relevant policies.

During interviews, I avoided soliciting potentially identifying information—including name, age, race/ethnicity, and immigration status. Such information instead often emerged during ethnographic observations and/or interviews. I recruited patients during observations, and I recruited clinic workers through professional networks, snowball sampling, and during observations. Patient participants represented a range of backgrounds. The distribution of 21 women and 13 men (based on gendered pronouns and adjectives in interviews/observations) reflected documented trends in health care utilization by gender (e.g., Bertakis et al., 2000; Manuel, 2018). They also represented a variety of national origins spanning Mexico (highest proportion), Central America, and South America. Among clinic workers, the sample included more than three times the number of women than men, reflecting women’s overrepresentation in the “helping” professions (U.S. Bureau of Labor Statistics, 2021; Salsberg et al., 2017). Additionally, the majority of patient and clinic worker participants made some reference to their individual and/or community identity in terms of being “Latino/a” or “Hispanic.” Only a small proportion referred to themselves in terms of being “white,” “Anglo,” and/or otherwise not members of Latinx communities—primarily among the physicians, nurses, and social workers in the sample.

Patient interviews typically took place in the clinics I observed, and I usually conducted interviews with clinic and community workers in the clinics and/or community organizations where they worked. Interviews were audio-recorded and transcribed in their original language. I coded and analyzed the data using ATLAS.ti and constructivist grounded theory techniques (Charmaz, 2014) to focus on social processes, such as “negotiating risk” and “navigating public charge.” To contextualize these social processes beyond the subjective level, which I detail elsewhere, I also employed situational mapping and social worlds/arenas mapping and traced not only the relationships among social actors, but also among relevant “ideas, concepts, discourses, symbols, sites of debate, and cultural ‘stuff’” that I documented throughout the study and which illuminated uneven power dynamics (Clarke, 2005: 88). These strategies, alongside deeper engagement with the legal estrangement literature, attuned me to evidence of situational trust amid such estrangement.

TABLE 1 Research site sample, demographics, and policy context.

Blue state	Red state	Purple state
<i>n</i> = 27 (9 patients, 18 clinic/ community workers)	<i>n</i> = 32 (13 patients, 19 clinic/ community workers)	<i>n</i> = 21 (12 patients, 9 clinic/ community workers)
Type of clinic observed: FQHC	Type of clinic(s) observed: FQHC and free clinic	Type of clinic(s) observed: free clinic
Widespread Sanctuary City/County Jurisdictions	No Sanctuary City/County Jurisdictions	Few Sanctuary City/County Jurisdictions
Expanded Medicaid (ACA)	Expanded Medicaid (ACA)	Did not expand Medicaid (ACA)
Provides state-funded Medicaid to certain undocumented children and adults	Does not provide state-funded Medicaid to any undocumented immigrants	Does not provide state-funded Medicaid to any undocumented immigrants

LEGAL ESTRANGEMENT AND PATIENTS' BENEFITS NEGOTIATIONS

As previous scholars have documented among hyper-surveilled individuals and communities, patients in this study expressed a sense of heightened visibility that made them wary of drawing additional attention to themselves through their institutional interactions. Their accounts also revealed, however, that they understood this visibility as variable through time (depending on the political conditions of a particular moment) and space (depending on the specific institutions and geographic parameters—local, state, or federal—in play). In trying to exercise some agency over the tension between their variable visibility and the structural exclusion that estranged them from social services, many struggled with the perception that they would be criminalized through any engagement with state welfare institutions. In this section, I describe how patients tacitly articulated and responded to conditions of legal estrangement and document some of the situational strategies they employed to mitigate that estrangement during a time of political uncertainty.

Some patients managed this condition by trying to avoid situations where their lack of legal status might cause trouble. For example, Javier, a patient I met in the red state in 2018, described a common feature of undocumented immigrants' legal estrangement: tolerating immediate personal insecurity rather than risking deportation. Referring to his experience of an especially anti-immigrant period in his state's recent history, he described how he would avoid reporting crime to the police because it was "counterproductive" and raised the possibility of immigration enforcement—which he correctly understood as a power devolved to local authorities in the area where he lived. Javier preferred to "keep quiet" to avoid such institutional entanglements altogether, even as he expressed that doing so might undermine safety in his community.

Yet these same fears somewhat paradoxically led Javier to enroll his children in the DACA program when the opportunity arose. This decision exemplifies "situational trust" (Bell, 2016) and the relative variability of institutional visibility as a perceived threat versus potential benefit (e.g., Asad, 2023; Fong, 2019). Because red-state law at the time of DACA's announcement (in 2012) was so intensely anti-immigrant, Javier perceived it as an immediate threat to his undocumented family and saw DACA as a way to regain some sense of control over that threat. Although Javier preferred to minimize his own visibility to record-keeping institutions, he wagered that the benefits of DACA within the context of anti-immigrant state laws would outweigh the risks of his family's new-found federal visibility. Yet when the Trump administration suspended DACA, Javier described a relatively high degree of legal estrangement that belied the tenuous nature of the situational trust he had sought. Echoing Bell's claim that legal estrangement surpasses individual distrust to encompass broader "anomie" in the face of social upheaval (Bell, 2017: 2084), Javier lamented, "[We] can't [make plans] because you don't know what will happen tomorrow, and it's something that makes you feel powerless...because you're afraid."

Patient Carina, who lived in the purple state, described similar variable visibility and legal estrangement in relation to social benefits and perceived surveillance. She qualified for a restricted form of Medicaid when pregnant with her US-born children, without which she would have faced significant financial strain, but she struggled to balance various perceived risks when enrolling them in Medicaid. She ultimately did so both because she understood enrollment as a “privilege” that their citizenship enabled and because one of her children was “born small” and required ongoing follow-up that made her reluctant to miss appointments. Like Javier, she weighed the threats that heightened visibility posed against the risks to her children’s wellbeing without it. Even so, negotiating these degrees of system involvement was a source of stress for Carina. “Because I thought that, since they [Medicaid] had my information, they [immigration agents] could come for me at any moment,” she explained to me in an interview in 2020. “You’ve always got that in your head, that maybe because of these processes I’ll end up without my kid and without a house in a place that I don’t even know [Mexico].”

Like Javier’s children, Carina attempted to apply for DACA before the Trump administration suspended the program, and she obtained a driver’s license before state law prohibited undocumented immigrants from applying for them. In each case, she wagered that the specific risks of maintaining an undocumented status (which she experienced once her entry visa had lapsed) in a state with punitive immigration politics, or driving without a license (an activity she could not avoid in the rural area where she lived), outweighed the more abstract risks of institutional visibility. However, because she could no longer renew her license, and because local law enforcement racially profiled Latinx drivers at checkpoints in her area (e.g., Armenta, 2017; Provine & Varsanyi, 2020; Stuesse & Coleman, 2014), she had been pulled over and received multiple tickets for driving with an expired license. She paid the tickets but received a letter from the Department of Motor Vehicles stating that she would be arrested the next time police stopped her.

Meanwhile, Carina’s DACA application was in limbo after the Trump administration suspended the program. She had provided extensive documents to the federal government, but someone with legal expertise recently told her to abandon her DACA application to avoid drawing attention to herself. Thus, by the time I met Carina, she felt surveilled by both the state and the federal government. Like Javier, opportunities for Carina to engage situational trust in certain governmental institutions under specific political conditions altered once those political conditions changed and became more uncertain, thus upending the risk calculations upon which she had negotiated that trust. The shifting background of Carina’s ongoing surveillance therefore exacerbated her broader social exclusion and extended her legal estrangement beyond punitive institutions.

Patient Laura described facing similar challenges to those Javier and Carina mentioned. I met Laura and her father at a free clinic in the red state in June 2018. At the time, as family separations at the border sparked global outcry, Laura’s father was recovering from an intensive hospitalization. Laura and her father were undocumented, but she had US-born children and a sister with DACA. Her family had arrived in the United States in 1996 and was raised with warnings to stay inside at night because immigration officials were always watching. “So you grow up with that fear already,” she explained. This fear, alongside federal and state policies that long excluded undocumented and liminally legal immigrants from health insurance, prevented Laura’s father from seeking health care when he began experiencing distressing symptoms that were likely related to advanced diabetes. Only when he could no longer ignore the symptoms did her father agree to go to the emergency room, and now he needed round-the-clock care and dialysis.

Laura found this situation alarming, but she struggled to overcome her immigration enforcement fears when it came to prioritizing her own diabetes-related health needs and support services for her son, who had autism. Believing that she should not seek health and welfare benefits because doing so would trigger immigration consequences, Laura came into conflict with her son’s school, where she was frequently chastised for failing to apply for the autism support services for which he was eligible. Laura recalled her son’s teacher saying, “I don’t understand how you never looked for services because, with the needs that he has, you have to fight for services.” Such criticism was difficult for

Laura to bear because she felt she was prioritizing her children by avoiding situations that might lead to her separation from them, even if this led to vicarious marginalization and estrangement for her US-born son.

Laura's experiences underscore how legal estrangement can spill beyond the bounds of law and immigration enforcement to affect other vital institutional settings. Like other patients I spoke with, Laura's family often felt like they were in a lose-lose situation where their wellbeing and security were concerned, and many of Laura's enduring fears seemed justified as she watched news from the border and heard renewed warnings about the public charge rule. In addition, like Carina, Laura had previously been stopped by police on a dubious traffic charge, and she was even arrested and briefly detained in jail. Laura physically shook as she imagined what would have happened if she had been deported on that occasion, and she took seriously the warnings she heard about interacting with any government agencies. "Because on the news they say that help from the government is the number one thing that will affect you as an undocumented immigrant," she explained, adding that friends and family also told her, "if you get help, they're going to deport you... They're going to come to your door, looking for you." Emphasizing how negotiating situational trust involved engaging in a calculated risk management strategy, Laura explained that it was only when faced with an unavoidable emergency that she and her family would "take that risk" of seeking health care despite fearing "that once they give us [medical] attention, they can report us."

The accounts of Javier, Carina, and Laura illustrate similar attempts to negotiate "selective visibility" (Fong, 2019) based on threat assessments that varied according to both political uncertainty and perceived medical severity. The concern that they expressed over compromising their family's security through lawful use of public benefits—including for US-born children—emphasized the spillover effects that anti-immigrant policies like the public charge rule can have on mixed-status families. While at one moment it may seem less risky to seek DACA protections than await possible deportation, or a health condition may become so dangerous as to outweigh the fear of family separation, engaging with non-enforcement institutions under conditions of legal estrangement was never without risk. This in turn resulted in a "chilling effect" that similarly shaped the material realities and legal estrangement of individuals with different legal statuses.

The case of Analisa's family further illustrates how legal violence can foster legal estrangement among differently situated family members. As far as I know, 18-year-old Analisa was the only patient I spoke with who was born in the United States. Although she was a patient of the clinic I observed, we talked mostly about her brother, another US-born citizen, who had recently died due to complications from a congenital liver disease. He had been unwell all his life and recently needed a liver transplant to survive, a procedure that his Medicaid would have covered if he could have gotten an organ transplant in time. For reasons Analisa could not understand, however, her brother's transplant was continually delayed. When we spoke, it had only been a few days since he died, and through sobs she explained that he had been on the waitlist for a long time but never seemed to advance. In addition, although he eventually did receive a transplant, he died shortly afterwards for reasons that were still unclear to Analisa's family.

At one point in her brother's long medical saga, doctors suggested that Analisa's father might consider donating part of his liver to his son. Because he was undocumented and uninsured, however, Analisa's father would have to apply for state-funded Medicaid (available to federally unqualified immigrants only in exceptional cases) to cover the transplant costs. Despite Analisa's parents' long-term avoidance of public benefits, which Analisa said her mother feared would lead to government penalties for Analisa and her brother when they were older, Analisa's father agreed to enroll in state-funded Medicaid.

While initial tests determined that Analisa's father was a match for the transplant, for reasons unknown to Analisa, this plan ultimately did not proceed beyond that stage. Instead, Analisa's brother remained on the waitlist, and her family continued struggling to make ends meet while ensuring that someone was always at her brother's side. Yet despite hospital workers' attempts to enroll Analisa's family in additional public benefits to help them endure their son's ongoing medical

crisis, her parents drew the line at the state-funded Medicaid. Whereas they were willing to risk enhanced institutional visibility when they believed it could save their son's life, Analisa's mother continued to express fear that other benefits use would have negative consequences on her US-born children. "She doesn't know if that's true or not," Analisa concluded, "but she just doesn't I want to risk it..."

Like Carina and Laura, Analisa's experience underscores how legal estrangement can spill over onto those who are not directly subject to law or immigration enforcement through its extension into non-enforcement spaces and lead to collective and vicarious estrangement (Bell, 2017; Ramirez, 2021). While medical institutions are certainly sites of discipline and surveillance (Foucault, 1973), especially for those who have had contact with the criminal legal system, these accounts illustrate how they may also be unexpected sites of legal estrangement for citizens and non-citizens alike. As anti-immigrant politics intensify the role of enforcement, medical legal violence thus insinuates itself more deeply into the bureaucratic structures of clinic spaces and extends estrangement from the criminal legal system (including the immigration system) to more supposedly benevolent institutions.

Finding spaces of procedural legitimacy amid estrangement

Even as rising medical legal violence stratified the health chances of patients across a variety of legal statuses and extended legal estrangement into vital institutions, the previous examples echo what existing research also suggests: that this condition of estrangement is not absolute. There are spaces for members of over-policed, over-surveilled communities to enact proactive strategies that may establish "situational trust" in otherwise suspect institutions and/or engage in "everyday resistance" against unjust legal arrangements (Bell, 2016, 2019). In addition to negotiating shifting situational trust around programs like Medicaid, DACA, and driver's licenses depending on perceptions of relative risk, participants sometimes expressed faith in procedural legitimacy in the form of civil rights that appeared more durable than other politically volatile programs (such as DACA).

I met free-clinic patient Alejandra in the purple state in February 2020—5 days after the 2019 public charge rule went into effect. Like others I spoke with, Alejandra believed that being undocumented made her ineligible for any public assistance, including health services, and she had good reason to be cautious after her son was deported following a traffic stop and her husband "self-deported" to join him in Mexico. This wariness meant that in addition to being unable to access the ongoing diabetes care she needed, she also avoided Emergency Medicaid even when she faced health emergencies—such as needing urgent colon surgery—in the past. And yet, immigrant advocacy efforts in her small purple-state community tempered this estrangement to some degree. Her reflections reveal that within a broader context of legal violence that excluded many noncitizens like Alejandra from social benefits, immigrant rights advocates' efforts to resist criminalization and surveillance helped foster situational trust in particular legal spheres.

Specifically, Alejandra detailed several "Know Your Rights" trainings in the community and emphasized how such efforts bolstered noncitizens' ability to resist anti-immigrant intimidation. Alejandra described seeing announcements and pamphlets throughout the community that informed immigrant families of their rights and provided instructions on how to respond if someone knocked at the door claiming to be an immigration enforcement official. "They [the Know Your Rights activists] give us advice," Alejandra explained. This advice included guidance that unless someone had a warrant, Alejandra did not have to open the door. "They can't force you to open it," Alejandra affirmed.

Alejandra expressed that she appreciated receiving this information where she could "see" her rights written down, and her appreciation reflected situational trust in local immigrant rights activists whom she perceived as a rare line of defense between her and punitive state agents whom she had good reason to distrust. While this situational trust did not suffice to overcome her avoidance of

publicly funded health care (instead, she attended the donation-funded, immigrant-run free clinic where I met her), holding a piece of paper on which her rights were inscribed helped counter the weight of uncertainty, confusion, and intimidation that circulated in her community. “Even though we may be illegal,” Alejandra asserted, “whatever the case may be, these are people who also have rights ... Now with the help they’ve given us, what they’ve told us and what we can do, our rights, now we can defend ourselves a little better.” Alejandra’s faith in the Know Your Rights trainings suggests that immigrant rights activists in her community were successfully promoting situational trust in at least some aspect of the law—in this case, constitutional rights to privacy and due process.

Unlike Alejandra, fellow free-clinic patient Julieta had been able to secure legal status and eventually naturalize as a US citizen. When I spoke with Julieta at the clinic in February 2020, the mother of three described that, 20 years ago, it was relatively easy for her to get restricted Medicaid as a non-citizen for pregnancy and childbirth-related care. Her sense of procedural legitimacy that was born of successfully naturalizing and engaging public benefits without penalty had begun to erode, however, as she perceived many new “conditions” being placed upon immigrants seeking health and wellbeing benefits since the 2016 presidential election. Despite the security that came with having US citizenship, Julieta felt a shift in some of her neighbors’ attitudes toward the Latinx community. She described the fear she experienced going shopping locally and perceiving that “the Americans” did not want her there, and she felt more subject to racism and the possibility of having to defend her presence in the country—for example, by having to show her “papers.” “All of a sudden you started to feel that tension, that fear. Like they [white US citizens] felt like they had more power.”

Julieta’s reflections suggested a growing sense of legal estrangement at the same time that it led her toward new strategies to negotiate situational trust and reassert control under conditions of political uncertainty. She joined the Democratic Party and began campaigning for a Latino candidate who was running for a local political office. She also cited the existence of the free clinic where we met as one example of how resources could be mobilized to benefit members of the community who were often estranged from social support at the local, state, and federal level. “[The free clinic’s founder], he’s Hispanic, and he worries about his people,” she remarked. “He doesn’t charge us anything. He doesn’t even ask for our address, or check stubs. ... I think that’s what it means to worry about your people. I think it would work the same in politics.” In addition to revealing how the free clinic fostered situational trust by limiting its surveillance practices relative to more formal governmental institutions, Julieta asserted that by following this example, members of the Latinx community could reassert a sense of control and change the political situation in their favor. Such statements revealed the possibility of restored procedural legitimacy if political activism could alter the specific structural conditions in which exclusionary laws emerged—in this case, by cultivating trust in co-ethnic ties and dismantling some of the relational and bureaucratic barriers that Julieta perceived as particularly discriminatory and untrustworthy.

Likewise, blue-state resident Mónica, who had become a US citizen after decades living in the United States, also described feeling targeted by the anti-immigrant rhetoric around the 2016 election and became active in politics, particularly efforts to protect Medicaid funding and expand comprehensive health care to everyone irrespective of legal status. While Mónica’s naturalization did not make her immune from rising anti-immigrant sentiment, she worked hard to counteract the weight of negative stereotypes that disproportionately fixated on “criminal” immigrants. “And we all pay for them,” Mónica remarked, “because we were also illegal.” Like Alejandra, who felt disoriented from any social support service based on her legal status, and like Julieta who continued to refer to “Americans” as an outgroup from which she—a US citizen—was excluded, Mónica’s description of herself as formerly “illegal” suggested ongoing legal estrangement that transcended formal citizenship categories. Despite such estrangement, however, Mónica’s ability to finally qualify for the social benefits schemes she had paid into for decades, and to become a political activist for those very programs, demonstrated faith in specific aspects of procedural legitimacy. Even as the estrangement of her own de-legitimation endured through ongoing anti-immigrant rhetoric and policies, Mónica saw effective value in

using her newfound political enfranchisement to support particular programs that might mitigate the harms of accelerating legal violence.

ENCOUNTERING ESTRANGEMENT AND NEGOTIATING TRUST

At the same time that patients described aspects of legal estrangement through their experiences with the US immigration and healthcare systems, community workers recalled their own struggles to facilitate care and negotiate situational trust as medical legal violence accelerated. In this section, I describe how safety-net workers not only observed the consequences of legal estrangement among patients, but also how workers themselves experienced and resisted that estrangement under a variety of personal and political conditions. Clinic workers' individual, collective, and professional identities—as well as their location in institutions subject to various degrees of governmental oversight—shaped how they responded to political uncertainty and imagined solutions to renew diminishing trust in clinical spaces.

Sometimes clinic interactions revealed a disconnect between a patient's experiences of legal estrangement and clinic workers' enduring faith in procedural legitimacy. On several occasions, I observed patients decline services for which clinic workers knew them to be eligible. This included a Central American asylum seeker who asked to be disenrolled from clinic services because she feared immigration enforcement officers would see clinic records and deport her, as well as numerous non-citizen parents of US citizen children who enrolled their children in Medicaid but explicitly declined other social support services (typically nutritional assistance). On some occasions, the clinic workers directly reached out to legal experts for specific advice, but more often, they provided patients with governmental forms outlining public charge criteria and tried to persuade wary patients to trust the validity of those documents. Such strategies revealed that their response to patients' expressions of legal "anomie" was often to recommend procedural legal remedies. Yet, as the rules governing public healthcare benefits have become more exclusionary since the mid-1990s and more bureaucratically intricate under the ACA, the pathways to care for noncitizen patients and mixed-status families also have become more convoluted. This made it harder for clinic workers to equitably meet the healthcare needs of patients experiencing compounded structural exclusions.

Importantly, because of the extensive influence of federal immigration lawmaking and healthcare administration, I witnessed similar challenges irrespective of the state context I observed. Despite differences in local immigrant-integration politics among the three study sites, the safety-net clinic workers I met described many similarities in local Medicaid practices. Even in the progressive site, where state-funded Medicaid enabled greater access to services for patients irrespective of legal status, many participants described situations of misinformation and intimidation that aligned with restrictive rhetorical and regulatory trends in more conservative states and at the federal level. As medical legal violence intensified within clinic spaces, safety-net healthcare workers described multi-layered constraints to their vital work that suggested an extension of legal estrangement through healthcare institutions. And while the presence of federal laws was relatively uniform across the sites, local political conditions extended legal estrangement in unique ways. This ranged from fears that enforcement agencies might target clinic patients and workers (all three states), to observing enforcement agents near the clinic (red state), to actually being subject to investigation by state officials (purple state). These dynamics frequently triggered emotional responses among clinic workers and often sparked targeted strategies to counteract eroding situational trust.

Well before the Trump administration announced plans to expand public charge inadmissibility criteria in October of 2018, safety-net healthcare workers serving immigrant communities faced increasingly anti-immigrant messaging in the local public benefits offices that they worked with daily to facilitate patients' wellbeing. Beatriz, a community organization leader I met in the politically progressive state in 2015, described significant uncertainty around noncitizens' public benefits eligibility. She found that this led to misinformation that workers in the county's Medicaid offices—even in the

most immigrant inclusive county of my three fieldsites—used to intimidate immigrants in the community. “What is being told to people that don’t have immigration status,” Beatriz remarked, “is that ... the [applicant’s] information goes to Immigration Services, the Immigration Department.”

Beatriz described a county safety net meeting where attendees expressed confusion over the possible connection between state Medicaid funding and immigration agencies. Many of the Medicaid workers voiced their impression that Medicaid shared applicants’ documents with immigration agencies. A legal expert present at the time informed them that federal regulations required Medicaid offices to maintain a record of the immigration information that noncitizen applicants provided, but that they did not independently send documents out to immigration agencies. Nevertheless, Beatriz continued to hear about Medicaid eligibility workers who warned applicants that they “had to” report their immigration information to immigration agencies. She explained that this became a “fear factor” when people heard from a “trusted community member” in a Medicaid office that applying for state-subsidized health benefits could jeopardize their immigration situation.

This fear factor—based on perceived surveillance through non-enforcement government agencies—often prevented noncitizens from applying for benefits for which they likely qualified, resulting in medical disenfranchisement via legal estrangement. In addition, the consequences of such estrangement touched Beatriz, who was a member of an immigrant family herself, personally. She recounted how her nephew—desperate to avoid public benefits agencies after his family’s humiliating experiences with them in the past—instead engaged in illicit activities to make ends meet. “I get very sad when I hear people going through the system and the way that they are being treated because it reminds me of why my nephew wouldn’t want to apply,” she recalled, “his fear factor and the things that he did and what ultimately got him killed.” Her reflections underscore that, even in a politically progressive area where people like Beatriz worked diligently to counteract misinformation born of federal policy uncertainty and the ongoing racialized structural exclusion of immigrant communities, the consequences of legal estrangement were far-reaching.

Enrollment counselor Isabel, whom I also met in the progressive county in 2015, echoed Beatriz’s claims that many of the eligibility workers at the county Medicaid often actively spread misinformation to intimidate noncitizen patients out of care. She recalled several such cases and emphasized that many of the workers at the county’s Medicaid offices compounded patients’ confusion through willful misinformation. “[We] had a lot of cases of [Medicaid] eligibility workers who were intimidating our patients,” Isabel remarked with audible frustration, “letting them know that, if they opted to [apply for public benefits], Immigration was going to come for them and was going to deport them.” Isabel, herself a Latina immigrant who had previously been undocumented and faced similar intimidation at Medicaid offices, continued, saying, “[Those workers] always say something like, ‘They’re going to deport you because we’re going to share this with Immigration.’ Just the fact of saying ‘immigration’ can be enough for someone to opt not to [apply].”

Isabel’s and Beatriz’s personal and professional reflections illuminate the ways that legal estrangement can extend into safety-net clinic spaces. Beyond formal policing or immigration enforcement institutions, these workers—like the communities they served and of which they were a part—increasingly viewed a government welfare agency (Medicaid) with suspicion because of its perceived alignment with a punitive arm of the state. Unlike the noncitizens they served, Beatriz and Isabel were not directly estranged through these structural arrangements at the time of our interviews. However, their overlapping social positions allowed both to understand these exclusionary structures and discriminatory institutional practices as barriers to the situational trust in the safety-net services they aimed to foster among those patients. Their observations underscore the linkages between the criminal legal system and the welfare state and how these alignments undermine care for Latinx immigrant communities by extending a sense of surveillance beyond enforcement agencies.

As anti-immigrant rhetoric escalated during the 2016 presidential race and into the early years of the Trump administration, the ability of safety-net workers like Beatriz and Isabel to get solid information to promote situational trust in safety-net institutions eroded. This level of uncertainty

exacerbated existing challenges to optimizing care for noncitizen patients who qualified for restricted benefits. Previously, safety-net clinic workers could often persuade gravely ill patients to enroll in such care in matters of life or death, especially in the progressive county (where state-funded Medicaid, especially in cases of serious but not emergent medical need, was the most expansive). Clinic workers' perception of changing federal priorities and the possibility of intensified surveillance under the Trump administration, however, began to diminish their own institutional trust.

Kelly, a breast cancer care coordinator at a private hospital in the progressive county, spoke about this tension in November 2016. She explained that she often counseled fearful cancer patients about the services that were available to them—including state-funded treatment resources. Kelly began by outlining the risks involved, “the main risk being that immigration services would find out about that they were undocumented and there could be consequences to that.” She highlighted the many potential benefits to receiving state-subsidized coverage, but she also acknowledged how difficult it was for patients to trust her and make the decision to prioritize their health over their immigration enforcement anxieties. “You are kind of balancing different fears and needs,” she remarked. “It’s a difficult conversation to have.”

Before the election, Kelly described confidence in patients' ability to get health services without immigration penalties because of the state's expansive noncitizen eligibility criteria. I had spoken with Kelly a few days after the 2016 election, however, which had suddenly destabilized these dynamics and brought the federal immigrant health regime more in line with that of more conservative states. Kelly became emotional when she began to consider how the Trump administration's pursuit of aggressive anti-immigrant enforcement and benefits policies might impact the noncitizen patients she served. Her tearful response signaled diminished trust in procedural legitimacy and opened her eyes to the heightened possibility of clinics being subjected to immigration enforcement surveillance in ways that could undermine noncitizens' cancer care. It also signaled how any federal administration may avail itself of the existing framework of legal violence in the United States if it so chooses. Therefore, while Kelly's reflections were specific to the arrival of the Trump administration, they revealed that antagonistic lawmakers may at any time target immigrant-inclusive policies at the sub-national level.

A month after meeting Kelly, I spoke with Anya, an oncology social worker in the same county as the blue-state clinic I observed. In the month after the 2016 election, she had begun receiving calls from concerned noncitizen patients who were enrolled in state-funded Medicaid for their cancer treatment. They expressed fear that immigration enforcement agents would be able to see their undocumented status in hospital records and “come after” them through their Medicaid use or charity care programs. Musing on the uncertainty she and the oncology patients faced after the election, Anya remarked, “I don't know what's going to happen, and I feel horrible when I say, ‘I can't tell you because I don't know.’” Like Kelly, Anya reacted emotionally to the realization that the procedural legitimacy she previously relied upon to facilitate noncitizens' care may have diminished under changing political conditions. Once those conditions changed, Anya was less able to trust existing procedures and therefore less able to mitigate patients' legal estrangement within the clinic.

Nearly 2 years later, in June 2018, political uncertainty persisted and had begun to manifest as a chilling effect in Medicaid renewals. When I spoke with clinic supervisor Olivia in the progressive fieldsite that month, she explained that she and her colleagues were struggling to encourage patients to enroll in benefits for which they and their families were eligible. Whereas previously she felt confident providing eligibility guidance to anxious patients, the shifting rules meant that she and her coworkers no longer knew how to provide clear guidance. “There's so much uncertainty, which is generating this stagnation [in Medicaid renewals],” she explained. “Even with our [non-governmental] programs here in the clinic, everyone has this fear that no one will be able to move forward with anything that's associated with immigration.” Such comments emphasize how political uncertainty both extended patients' legal estrangement more pervasively into clinical spaces and disoriented clinic workers as a sense of broader social upheaval eroded their trust in procedural legitimacy.

Olivia expressed frustration over not having a “clear message” to provide when people needed concrete information to make decisions about their health. As rumors of a public charge expansion began to circulate ahead of the Trump administration’s notice of proposed rulemaking in October 2018, Olivia witnessed escalating fear and anxiety. Even though few people had specifically heard of the public charge rule itself before the Trump administration, they became acutely aware of its existence and increasingly avoided services they thought might lead to immigration enforcement harms. Olivia expressed these developments as a destabilization of longstanding trust that the clinic had cultivated in the Latinx community over many years. “Now it’s not that they don’t trust us,” she remarked. “But since we’re not confident, like, we’re—it’s difficult,” she continued, struggling to articulate the precise consequences of political uncertainty making its way into the clinic.

By 2018, Olivia and her colleagues were at a loss to reassure increasingly fearful patients. “That’s why we’re having lots of meetings—nobody knows anything for sure,” Olivia remarked, recalling colleagues’ fears that they might have to turn over medical records to immigration enforcement officials, as well as concerns that their own immigrant staff might be put at risk by such encounters. “The meetings we’ve been having now are really scary because it seems like everything’s going to be public charge, even [our state health insurance exchange] could be public charge,” she said. That it was not only clinic patients, but clinic workers themselves, who found the situation “scary” reveals conditions of social disorder that subverted the mundane bureaucratic activities characterizing street-level personnel’s everyday work in organizations. Olivia added that she felt “really angry” about how much time she and her colleagues were having to devote to speculating about immigration enforcement when their job was to provide care for the community they served. Like Anya and Kelly, Olivia’s emotional response signaled a sense of disorientation as political uncertainty in the progressive state overwhelmed previous faith in procedural legitimacy. These reactions demonstrate more than distrust, however; they reflect a sense of bewildering “anomie” in what they perceived as unanticipated, disruptive, and profound social change.

Meanwhile, in the red and purple states, where state-subsidized care was not available for unqualified immigrants at any time during the 2015–2020 study period, the immediate impacts of the transition to the Trump administration were more subtle. Their respective political contexts were already relatively antagonistic toward Latinx immigrants, and those I spoke with perceived an intensification of such sentiment rather than a novel set of circumstances. Even so, as the Trump administration pursued more aggressive immigration enforcement strategies while promising to dismantle DACA and expand public charge, patients and clinic workers alike expressed growing alarm. As the patients I described above recounted mounting uncertainty and fear around family separations, DACA, and the public charge rule, clinic workers also had to grapple with new uncertainties.

As in the blue state, red-state clinic worker Liliana described how—well before I met her in October of 2017—misinformation in public benefits agencies dissuaded immigrant families from enrolling in benefits such as food stamps and full-scope or restricted (Emergency) Medicaid, even if some members of the family were eligible. Relatively recent state legislation, which had been overturned by the time of this research, criminalized not only undocumented immigrants but anyone who was suspected of concealing their presence through sheltering them or providing transportation. Liliana remembered enduring fears in the community that living with or helping an undocumented immigrant could lead to arrest, and that undocumented parents could be deported for enrolling their children in Medicaid. Other clinic workers I spoke with in the state recalled seeing immigration enforcement vehicles and even a “tank” parked outside of healthcare facilities during that time. Because of—and despite—these intimidation tactics, Liliana described clients coming to her office in tears seeking reassurance from clinic workers.

Liliana’s reflections reveal that while under specific political conditions members of criminalized and surveilled immigrant communities might develop sufficient trust in procedural legitimacy to apply for Medicaid and/or DACA, the renewed federal destabilization of that tenuous situational trust extended “anomie” into clinical spaces in new ways. As the Trump administration took aim at DACA, Liliana observed parallel situations of distrust unfolding between health care and

immigration law negotiations. Just as patients feared government exposure through Medicaid when state laws suggested vicarious criminalization, DACA recipients began coming to the clinic to express concerns that their documentation might place them under the Trump administration's radar. They asked trusted clinic workers like Liliana what would happen to them, but Liliana and her colleagues did not know the answers. Like Olivia, Liliana emphasized that in the face of broader social disruption, the clinic could no longer provide patients with a clear message, which troubled her greatly. Rather than trusting in existing procedures to protect patients from intensifying medical legal violence, Liliana and her colleagues struggled to negotiate care for their patients when they themselves felt uncertain about how social policies might be a source of harm rather than protection.

Dr. García, a red-state psychologist I spoke with in December 2017, bitterly recalled the years of the state's anti-immigrant lawmaking and expressed concern over what the federal government might do with noncitizen patients' health information as she anticipated renewed attacks on immigrant families. As a provider, she especially worried about what information was safe to put in non-citizen patients' electronic health record (EHR). Recalling widespread confusion among service providers over whether state law previously required them to report a patient's immigration status to authorities or risk criminalization themselves, Dr. García supposed it would be "very easy" for the federal government to mandate that providers record someone's legal status in the EHR. She also wondered to what degree EHRs might be accessible to government agencies—particularly those intent on identifying and removing noncitizen immigrants.

Like other clinic workers, who experienced the extension of legal estrangement into clinical spaces as a heightened emotional response, Dr. García expressed feeling "angry" over having to worry about immigration enforcement in her clinical practice. She especially worried about the personal information that health insurance plans collected on patients—information she had to provide to get reimbursed. "Especially if there's any kind of government component to that," she added. "So, if it's [Medicaid], even if it's Emergency [Medicaid] ... in our intake information when we see somebody for the first time, we ask 'Where were you born and raised?'" Dr. García recalled a case in which a teenaged patient from Central America described journeying to the United States "illegally," during which time she was "raped a couple of times and ended up working for one of the big cartels." When she was 17, the patient was caught smuggling drugs and people, and she had recently been placed in foster care when Dr. García began treating her for post-traumatic stress disorder. "Now, how much of that do you document?" Dr. García asked. "...Some of it which is relevant to the treatment because I diagnosed her with post-traumatic stress, but how much of that do I document?"

Under conditions of policy uncertainty and social disruption, medical charting practices can thus become a site of conflict and key mechanism for the extension of legal estrangement into clinical spaces. While this was something of a hypothetical concern in the blue state and perceived procedural reality in the red state under changing legislative circumstances, the ever looming threat of surveillance manifested more concretely in the purple state. During my interviews there, for example, multiple clinic workers mentioned that the state had investigated a couple of local department of health clinicians for allegations related to care they provided to undocumented immigrants. The investigation had happened several years previously, but the collective memory of this event persisted in area safety-net clinics and contributed to a relatively high degree of legal estrangement among clinic workers—so much so that multiple clinic administrators apologetically declined to participate in my study due to explicit fears of reprisal by local elected officials.

In late 2019 and early 2020, I had the opportunity to speak separately with the investigated clinicians myself. In these conversations, they described institutional challenges they had faced trying to provide maternal leave letters for women who had recently given birth but who worked under aliases due to their legal status. They tried to work with the department of health to develop a charting system that captured patients' health information for the clinic's records without compromising their health privacy or security, but they encountered limited institutional guidance. In the process of

trying to develop an adequate charting system, a local elected official became aware of the situation and launched an inquiry with the state bureau of investigation.

Soon after, the elected official, department of health leadership, and the county sheriff showed up at the clinic and demanded the clinicians' badges and keys. They were thus suspended pending investigation on charges of violating state or federal identity theft and fraud laws by assisting undocumented immigrants' maintenance of assumed or stolen identities. This bewildered the clinicians because, as the sheriff himself acknowledged at a later board of commissioners meeting, they did not believe they were violating the law through their actions. They did believe, however, that withholding medical care from their patients based on their legal status would have violated the law. Minutes from this meeting reveal profound confusion among both clinic workers and law enforcement over which laws took precedence in such cases: those penalizing "criminal" activity (such as alleged identity theft), or those protecting patient health and privacy. Such laws include the 1986 Emergency Medical Treatment and Labor Act (EMTALA), which explicitly prohibits withholding lifesaving care from a patient based on their ability to pay or legal status, and the 1996 Health Insurance Portability and Accountability Act (HIPAA), which protects a patient's privacy.

Without a clear answer, state investigators pulled numerous patients' medical records and identified five undocumented immigrants who had received care from the clinic—one of whom was then processed for deportation. While the clinicians—who did not identify as Latinx—were cleared of all charges, they expressed a sense of legal estrangement similar to that articulated more frequently by members of the communities whose health care they provided. In addition, the notoriety of the investigation extended legal estrangement into safety-net clinic spaces throughout the area for years to come. The collective memory of this investigation thus surpassed an individual distrust of legal procedures and institutions and suggested a more pervasive and shared sense of powerlessness in response to medical legal violence. Moreover, this case reveals how the same estrangement that typically besets marginalized communities may also extend to an unanticipated and otherwise relatively powerful social group: clinic workers.

While the state investigation took place several years before the 2019 public rule change, it continued to resonate through conversations I had with other local safety net workers when the new rule went into effect. Caitlyn, a seasoned administrative assistant at the department of health, explained that confusion over medical records practices put her and her colleagues in a difficult position between maintaining compliance with state Medicaid laws and fostering trust with immigrant communities. She expressed frustration over what she perceived as new questions related to legal status that had made their way into patient forms and felt like she had no choice but to "follow the guidance given" by the state, especially since the state regularly audited her office. Likewise, Dr. Contreras, a primary care provider in the same state whom I spoke with in 2020, described how these new bureaucratic barriers were emerging "over the last three years" as applications for discounted care began demanding more sensitive information. He explained that patients now had to apply for Medicaid and prove that they had been denied coverage before seeking other forms of institutional financial assistance within the healthcare safety net—a procedure that some clinic workers in the red state also recently had observed. "Of course, it's another hurdle because they have to expose themselves [to government surveillance], just to the application process, even if they know they're going to be denied," he explained. He emphasized that this specifically affected the Latinx community, "who are obviously very vulnerable and are at risk for being identified by ICE [Immigration and Customs Enforcement] and being deported and having information in the system."

Dr. Contreras went on to describe how one of his long-term patients recently asked to be disenrolled from any financial assistance programs at the clinic (even though he had been lawfully enrolled for many years). He recalled the patient asking him, "Can you assure me that what I send to your institution will not be accessed by ICE and cause me to be identified and deported?" "I said, 'No, I cannot. That's not how the system works and how the laws are.'" Like Caitlyn, Dr. Contreras's reflections revealed not only the extension of patients' legal estrangement through the clinic, but how political uncertainty and procedural constraints often immobilized safety-net

workers as well. Absent clear legal guidance and specific strategies to sustain trust within institutions that require detailed formal recordkeeping, and which may be subject to state scrutiny, healthcare workers like Dr. Contreras had little recourse to reassure legally estranged patients who needed their care.

My research suggests that vicarious legal estrangement can extend beyond immigrant families and communities to the healthcare workers who facilitate their care, primarily through the perceived co-optation of medical institutional records for immigration enforcement purposes. The degree of such estrangement, in turn, may also vary depending on local political conditions. Whereas clinic workers in the blue state conveyed a sense of punitive potential as they imagined the possibility of immigration enforcement making its way into clinics, red state workers had already experienced a certain measure of criminalization-by-proxy through anti-immigrant legislation at the state level coupled with vague rumors and visible intimidation attempts near medical facilities. And in the purple state, collective memory of healthcare worker criminalization created a climate of suspicion and wariness that persisted for years in area safety-net clinics and revealed the alarming potential for policy uncertainty to extend legal estrangement into clinic spaces.

Negotiating situational trust through the clinic

As political uncertainty shifted clinic workers' orientations away from faith in procedural legitimacy (trust in the law and institutions) toward closer encounters with the legal estrangement their patients faced, they often expressed the types of emotional reactions described in the previous section. Yet such affective responses only capture part of the story. In this section, I describe clinic workers' efforts to reassert a sense of control amid estrangement, which they enacted from their unique social positions within healthcare institutions. In addition to feeling anger, uncertainty, and frustration, clinic workers also engaged in deliberate situation-specific strategies to promote trust in clinic procedures at the institutional level. They did so by leveraging specific laws that they perceived as still trustworthy (e.g., constitutional amendments and HIPAA) in lieu of more polarized political programs and agencies that they increasingly distrusted (e.g., DACA and Medicaid). In other words, clinic workers began embracing procedural legitimacy on their own terms by redefining that legitimacy in terms of trust in clinic procedures rather than wholesale procedural legitimacy of state institutions writ large.

Much like the Know Your Rights trainings that patient Alejandra mentioned, clinic workers began fostering domain-specific situational trust in response to growing threats of medical legal violence. Facing political uncertainty, many clinic workers reiterated the ethical commitments clinics had to prioritize patient wellbeing. For example, blue-state oncology social worker Anya seemed defiant when we spoke a few days before the election in November 2016. "We're going to treat [everyone]," she asserted, emphasizing that it would be "illegal and immoral not to treat [someone]" based on their legal status. Even so, she understood patients' concerns that, under a more punitive federal regime, clinic records documenting their use of state-funded Medicaid would draw immigration enforcement attention and lead to deportation. "I think that's where people are just afraid," she acknowledged, "but we're always going to treat them. Forget that; we'll always treat people." Like the clinicians subject to investigation in the purple state, whose understanding of federal health laws compelled them to provide care despite medical records confusion, Anya's comments suggest that she viewed the oncology department as procedurally and ethically bound by legal prohibitions on withholding care based on a patient's legal status.

Anya's remarks also underscore what the previous section illustrated: the pervasive concern among clinic workers across the three fieldsites that, in a climate of policy uncertainty and anti-immigrant politics, clinic records could become a punitive enforcement tool. Some healthcare workers, like Dr. García in the red state, began reconsidering their charting practices to anticipate such a possibility. She also worked with a colleague to help anxious patients create "emergency preparation kits" in case of sudden

family separation. These included children's birth certificates and a letter of guardianship or power of attorney. Dr. García encouraged patients to make multiple packets and store copies in more than one location. She emphasized that healthcare providers were not required to know such immigration law nuances, but she had researched them because her patients needed that information. "For those who are fearful," she concluded, "...this is a way for them to get a little control over their life." By integrating such practices into her clinical work, Dr. García converted some of the therapeutic trust embedded within her medical role into a strategy that enabled patients to feel some agency over overwhelming threats to their family's safety during a time of intense social disruption.

Over time, many of the clinics I observed seemed keen to systematize practices like the ones Dr. García described. For example, at a large administrative meeting in December 2017, red-state clinic workers acknowledged rising anxiety in the Latinx community but focused on what actions they could take to increase their collective power and avoid being "at the mercy of any administration or agency." Clinic leadership encouraged staff to register to vote, pay attention to local campaigns, and contact their elected officials to share patient stories and put a human face to their work. Such strategies suggest some degree of enduring trust in procedural legitimacy, even as their reluctance to be "at the mercy" of governmental institutions signaled wariness of anomic conditions that might undermine patient care. Rather than trusting in the existing structural arrangements that shaped their work, the clinic engaged in activities that might consolidate and extend their institutional power and advance their own care-centered agenda. Responding to uncertain and antagonistic political conditions therefore involved efforts to systematize protective practices that might promote patient trust at the institutional level and political mobilization to mitigate the structural conditions of their patients' legal estrangement.

Their blue-state counterparts, meanwhile, held Know Your Rights trainings and implemented protective protocols against immigration enforcement activities—including warrant trainings and emergency preparedness planning like Dr. García had described. In October 2017, for example, I attended a conference focused on how regional safety-net clinics could protect immigrant communities from federal immigration enforcement activities. At the conference, immigration law experts, advocates, and elected officials provided guidance on how healthcare organizations could create safer spaces for immigrant individuals and families. The featured speakers' remarks rang with impassioned urgency. "We are at the center of the resistance," one elected state representative declared, and immigration law experts followed with detailed guidance on privacy law, immigration laws, and health and welfare governance. Workshops throughout the day focused on topics such as understanding HIPAA protections in relation to immigration enforcement and how to differentiate between administrative and judicial warrants.

Such "resistance" rhetoric illustrated not only the evocation of a collective experience of anomic structural conditions that encompassed groups occupying various, sometimes overlapping, social positions—namely, immigrant communities and safety-net healthcare workers. It also revealed how, in response to the extension of legal estrangement into healthcare spaces, clinic workers leveraged specific institutional procedures rooted in laws that seemed the least politically volatile—namely HIPAA and constitutional amendments regarding privacy and due process—to foster patients' trust. And, importantly, they sought to promote this situational trust by focusing on the practices and procedures of the clinic itself. Their collective distrust in the broader procedural legitimacy of punitive state institutions persisted, but they found ways to resist the incursion of medical legal violence into the clinic and reprioritize patient care. Rather than absolute trust in procedural legitimacy, they identified specific legal strategies that could bolster protective practices at the institutional level and restore trust amid patients' and workers' broader sense of estrangement.

CONCLUSION

In this article, I have contextualized policy uncertainty around the public charge rule through the lens of medical legal violence and shown how political uncertainty extended legal estrangement into

clinic spaces. Beyond simply providing additional evidence of a chilling effect in immigrant communities' healthcare access, I have also explained how the sense of enhanced visibility that participants associated with institutional recordkeeping enabled the extension of legal estrangement through medical institutions. Whereas existing scholarship has focused primarily on the ways that policing and immigration enforcement affect how members of socially marginalized communities seek and/or avoid social services (e.g., Armenta & Rosales, 2019; Armenta & Sarabia, 2020; Asad, 2023; Bell, 2016; Brayne, 2014; Ramirez, 2021), I have explored the consequences of the perceived incursion of this enforcement apparatus into healthcare spaces both for those who need care and those whose job it is to provide that care.

Through the accounts of participants who occupy distinct social positions in relation to the healthcare safety net, I have shown how political instability may intensify perceptions of individual and institutional surveillance in ways that upend participants' sense of control. In this way, medical legal violence creates unanticipated opportunities for healthcare institutions and personnel to become part of the punitive architecture of a safety net that disproportionately surveils and penalizes immigrants of color. This violence estranges individuals, families, and communities from equitable care and undermines workers' efforts to foster situational trust in the safety net under antagonistic conditions.

These findings have several practical implications. To the extent that legal experts can help clinics foster situational trust by anchoring institutional policies and practices in durable, protective laws that prioritize patient care, safety-net healthcare institutions would benefit from regular opportunities to seek such expert guidance (e.g., Regenstein et al., 2018; Sandel et al., 2010). Additionally, as we collectively reflect on the disproportionate impacts of COVID-19 on immigrant communities, the arbitrariness of exclusionary public policy becomes clearer than ever. Emergency measures that reduced immigrant enforcement activities and enabled the provision of care irrespective of legal status or insurance coverage—for example, to facilitate COVID testing and vaccination—demonstrated that such inclusionary practices were possible. Rather than reverting to the status quo as the nation enters the next phases of pandemic life, lawmakers should continue pursuing more inclusionary policies to prioritize public health.

While I have focused here on the context of immigrant criminalization and its spillover effects on immigrant-serving clinics, the extension of direct and vicarious legal estrangement into healthcare spaces is not limited to immigrant communities. Contemporary challenges to both gender-affirming and reproductive health care across the United States, for example, suggest that legal estrangement may also manifest in other highly politicized medical settings. Recent state laws that restrict such care involve intensifying multimodal surveillance—including medical records monitoring—that puts patients and healthcare workers at risk of criminalization while compromising care (e.g., Keith, 2023; Wright Clayton et al., 2023). Much as the climate of fear and anxiety surrounding public charge uncertainty reflects a new iteration of, rather than a fundamental change to, longstanding anti-immigrant policies, the estrangement generated by these gender-based restrictions on care represents renewed barriers to health equity within a long history of institutional discrimination.

For these reasons, it is vitally important to understand how situational trust may be successfully cultivated to counteract the harms of legal estrangement in a variety of clinical spaces. While the examples of situational trust I have discussed here do not remedy all the harms of medical legal violence, they do emphasize some of the ways that participants can enact specific practices to mitigate the extent of that harm. Such practices, however, must exist in coordination with broader efforts to resist the discriminatory structures that shape patient care in the safety net. Changing the public charge rule alone, or enacting ad hoc inclusionary practices to promote disease-specific public health aims, is insufficient for such a task. Addressing medical legal violence therefore involves not only understanding health and immigration laws to mitigate impacted communities' legal estrangement, but also acknowledging and dismantling the essential inequities embedded within its logic.

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AUTHOR BIOGRAPHY

Meredith Van Natta is Assistant Professor of Sociology at the University of California, Merced. Her research explores immigration and social welfare policies in the United States, as well as the intersection of citizenship and science, medicine, and technology policy. More information can be found on her website: meredithvannatta.com

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