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Challenges to medical ethics in the context of detention and deportation: insights from a French postcolonial department in the Indian Ocean

Abstract

Owing to a growing policing of borders, healthcare professionals become increasingly involved in the biopolitical management of migrants' mobility. While their presence on sites of migration control and detention is necessary to ensure migrants' access to healthcare, their role risks being instrumentalized to ensure the sustainability of detention and swiftness of deportations. This article analyses the practice and ethics of midwives' medical expertise in processes of migration control in the French overseas department of Mayotte in the Indian Ocean. Midwives in this setting are required to assess the health of pregnant women intercepted at sea by the police in order to determine whether they can be detained. The article traces how midwives come to be invested with a power to police patients' mobility. In the face of such unwelcome responsibilities, midwives resorted to emotional distancing while suspicion on both sides impeded the possibility of genuine relations of care. The article analyses how midwives framed the ethical dilemmas at hand and examines how they perceived their decision-making responsibility. I argue that midwives are socialized into the logics of border enforcement and gradually brought to implement a minimal version of care as a result of migration control's inroads into care. The article thus questions the function and meaning of biopolitics within migration control and aims at initiating a conversation around the necessary conditions for ensuring medical personnel's independence in these extraordinary care settings. The article draws on a three-months fieldwork completed in Mayotte between mid-April and mid-July 2017 during which I conducted 39 interviews with healthcare professionals in perinatal health services and 15 interviews with officers from stakeholder organizations, from local and international NGOs to health institutions. This

article draws in particular on interviews with the medical team that was required to attend to migrant women intercepted at sea by the police.

Keywords: Migration, Detention, Medical ethics, France, Pregnancy, Mayotte.

1. Introduction

> Since there's no legislation and there's no protocol, the decision is really up to us. (…) In fact, there's something that bothers me deeply about this, it's that I feel like I risk my diploma…each time I see a kwassa [referring to a woman who has just been intercepted by the police on a small fishing boat] I think about it all day. And sometimes in the evenings I still think about it. And it stresses me out because I feel like I risk my diploma. Last time I had a twin pregnancy at 31 weeks with a long cervix that didn't contract; I've sent her back. But all day I was thinking "and if something happens at the CRA [detention centre]? What if she goes into labour? What if there's a problem?"

This situation takes place in a small maternity centre of an overseas French department in the Indian Ocean, Mayotte, where midwives occasionally attended to women arrested by the police in order to determine whether or not their health was 'compatible' with detention. This island of approximatively 262, 000 inhabitants (INSEE, 2017a) became a formal French department in 2011 and a European ultra-peripheral region in 2014. Mayotte remained part of France further to the independence referenda organized by France in the mid-1970s. While the three other islands of the Comorian archipelago voted in favour of independence, Mayotte did not. Since then French sovereignty over the island has remained contested, as the Union of the Comoros claims that having organized a second referendum specifically in Mayotte on

the basis of results fragmented per island violated Comorian sovereignty (Tchokothe, 2018). Over the past decades, several resolutions of the United Nations General Assembly have supported the Comorian claim (Blanchard, 2019). The Mahoran elite in turn advocated for the island's recognition as French and in this regard the island's recent 'departementalisation' represents a political victory long fought for. Against this background, Mayotte witnessed a growing policing of its borders, notably following the adoption of the 'visa Balladur' in 1995, which rendered illegal local mobilities from the other islands of the archipelago to Mayotte (Geisser, 2016). Such migration restrictions entrap an undocumented population who are unable to circulate (Sakoyan, 2011; 2012); they are mostly of Comorian origin as Comorians make up 95% of foreigners in Mayotte (INSEE, 2019). 70% of births on the island in 2017 were to foreign mothers and approximatively half of the foreign population is estimated by the French National Institute of Statistics and Economic Studies to be undocumented (INSEE, 2017b). The strikingly high rates of undocumented persons residing on the island result from the implementation of a repressive migration regime across postcolonial borders, exacerbated by a derogatory administrative management of migration at the local level, which includes additional requirements for regularization compared to mainland France, while this process is costly and the local population faces severe socio-economic difficulties. As a result, midwives working in this maternity ward attended to a majority of undocumented women of Comorian origin. It has been documented that migration to Mayotte is not primarily motivated by access to healthcare (Sakoyan, 2011; 2012), and, similarly to French Guiana, pregnancy does not appear to constitute a significant migration motive (Carde, 2012b).

When intercepted at sea in small fishing boats called 'kwassa kwassa', the overwhelming majority of detained persons are deported back to the closest Comorian island of Anjouan within a few hours, owing to specific legislative dispositions that shape Mayotte's migration regime (GISTI, 2015). Though Mayotte presents the most exceptions, all French overseas

territories display various degrees of exceptionality, creating a multilayered system of migration governance that lays bare the myth of French republican indivisibility (Musso, Sakoyan and Mulot, 2012). The local detention centre (CRA) holds the record for the quickest deportations, on average about 17 hours after arrest (Ghaem, 2019), as well as for the highest rate of deportees of all French detention centres; in 2017, for instance, 94% of the 17 934 detained persons were expelled (La Cimade, 2018). Some of those intercepted at sea are able to see a doctor before being detained, which is usually the case for pregnant women, provided that their condition is known to the police. These women are brought to the small maternity centre where the situation described above took place. In this quote, the young midwife from metropolitan France shared her doubts about her decision to 'send back' a woman with a twin pregnancy. 'Sending back' in this context means that the midwife signs a medical certificate attesting to the patient's health state as compatible with detention. As a result, the pregnant woman is accompanied by policemen to the detention centre and most probably forcibly removed to the Union of the Comoros in the hours that follow, given the patterns of deportations in place in Mayotte. When the health situation of the woman is not deemed compatible with detention, she is either immediately hospitalized or prescribed a specific treatment to be monitored by the hospital or local health centres (and is thus staying in Mayotte as an undocumented person). While not physically intervening inside the detention centre, these midwives play a role in the local management of migration and in the steps leading up to deportation. Why did this midwife decide that the health situation of her patient, in a state of advanced pregnancy with twins, was compatible with detention? What are the circumstances of midwives' consultations with undocumented women arrested by the police? How do medical ethics play out within a system of migration repression?

To explore these questions, the first section exposes some of the ambiguities of the healthcare-migration nexus in the French context and reviews other case-studies researching

medical ethics within immigrant detention settings conducted in France, Germany and Australia. I then present the methodology that brought me to research the role of midwives within the deportation process of undocumented migrants in Mayotte. Building upon this case-study, the following sections grapple with the ethical questions raised by midwives' involvement in spaces of migration control. The first empirical section presents what the role of midwives entails within the process of migration control, questioning these practices from the perspective of the profession's deontological norms. The ethical dilemmas raised by these situations are analysed in the following section with particular attention to processes of emotional distancing that underpin these peculiar relations of care. Finally, the penultimate section argues that midwives' practices undergo a socialization by the repressive migration regime as a result of the problematic inscription of their medical activities within the governance of non-medical authorities. In my concluding remarks, I reflect on the slippery ground that healthcare professionals' involvement represents in settings of immigrant detention. While their role in this field follows the rationale of biopolitical governance, their participation appears to be Janus-faced, revealing the instrumentalization of biopolitics for purposes of exclusion.

2. Medical ethics, migration control and immigrant detention

A large share of the literature around migration and healthcare is concerned with the question of precarious migrant groups' access to healthcare services. In the French context, challenges to accessing healthcare, including various forms of discrimination, are increasingly documented (Cognet, Hamel and Moisy, 2012; Larchanché, 2012; Sauvegrain, 2012). In French overseas territories, culturalist accounts concealed the role of migration policies in undermining access to healthcare (Benoît, 2004). Another strand of literature revealed how

the question of access to healthcare became a migration policy in itself. Didier Fassin (2001) and Miriam Ticktin (2011) analysed the concomitant decrease in the number of people granted refugee status and the progressive institutionalization of a residency permit conceded on the basis of a severe illness, identifying a shift from a political to a biological moral legitimacy. Yet the emergence of the suffering body as a subject of migration policies engendered an increasing suspicion of state authorities towards doctors (Ticktin, 2011). This new role indeed turned healthcare professionals into peculiar border guards owing to the increasing relevance of their medical expertise through both the 'illness clause' (Ticktin, 2011) that made possible the granting of temporary residency rights on grounds of ill-health, and the growing role played by medical certificates in asylum applications (Fassin and d'Halluin, 2005).

This delicate position raised, early on, interrogations in terms of medical ethics. At the very least, medical ethics entail the principles of autonomy, justice, beneficence, and non-maleficence. From the Hippocratic oath, to its national adaptations, to the Declaration of Geneva adopted by the World Medical Association (WMA), medical professionals pledge a commitment to their patients that supposes high levels of independence regarding other authorities like the state, the military and places of detentions such as prisons or detention centres for immigrants. Yet in practice, it might be difficult to assess the ethics of medical personnel's engagement within such spaces. In 1997 for instance, further to the introduction in France of the residency permit justified by serious illness, the ethics of doctors' role in determining such rights were discussed by raising the question of whether public health doctors (employed by the state) should 'get their hands dirty' through being implicated in matters of immigration and deportation (Fassin, 2001: 14). While the doctors' implication was justified by relevant professional instances on the basis of an effort to avoid arbitrary

deportations, Fassin's research (ibid.) demonstrated that different departments (French regional districts) registered varied proportions of regularization based on medical grounds, revealing that a person would not have the same chances for regularization under this scheme from one department to another. Given that the administration usually followed medical expertise in its advice, variations owed ultimately to divergent medical practices as to what pathologies were considered to justify a residency permit. The unease created by doctors' involvement in forms of migration management was publicly acknowledged with the petition that Doctors of the World launched in 2007, calling for a deontological right to disobey, in an attempt to safeguard doctors' work from the clout of migration control (Musso, Sakoyan and Mulot, 2012). The power dynamics at play in these relations were further revealed by the decision to transfer in 2017 the medical decision-making from the Regional Health Agencies (ARS) to the medical service of the French Office of Immigration and Integration (OFII), where doctors depend hierarchically on the Ministry of Interior, leading to a marked decrease in favourable medical opinions (Fraysse et al., 2019).

In the context of migrants' detention, the ambiguous relations between migration control and healthcare are even more pervasive, yet also more hidden. There too, the expert opinion of doctors tended to be respected by the French administration, which virtually turned doctors into regulators of detained migrants' release on medical grounds (Enjolras, 2009). To be sure, medical personnel's presence is indispensable for accessing health services. Yet, although this involvement contributes to the realization of migrants' rights, its circumstances raise a set of ethical issues. The ambiguity of healthcare professionals' position, oscillating between ensuring access to health and enabling detention and deportation, deserves analytical attention. For instance, an ethical concern fostered doctors' resistance in some French detention centres to the systematization of medical certificates attesting to migrants' fitness

for travel, rejecting the logic of a 'sanitisation of deportations' (Enjolras, 2009: 78) that would blatantly assign doctors' work to the service of swift deportations.

Beyond the French context, several enquiries into the role of healthcare professionals in immigrant detention centres concur in foregrounding the ethical challenges attached to these settings. In Germany such 'use' of doctors became normalized, though criticized by professional associations, to the point where doctors are even asked to specify a medical procedure to follow for patients who in normal circumstances would not be considered healthy enough to fly (Nijhawan, 2005: 276). In Australia, while such 'fitness-to-travel assessments' have also become routinized, research into these practices revealed that mental health was not being assessed (Briskman, Zion and Loff, 2010: 1098). These tasks threaten to compromise medical personnel's commitment to patients and to their well-being. There is a risk of crossing a fine line between providing medical assistance for the improvement of a detainee's condition and the use of health services for the smooth enforcement of borders, and notably for their most repressive dimensions of detention and deportation. In the Australian context, medical professionals and social science researchers have been vocal about the ethical issues raised by doctors' and nurses' involvement in the system of mandatory imprisonment of asylum seekers implemented by the Australian government. Medical officers who worked at immigration detention centres critiqued, for instance, doctors' role in the assessment of patients' age, as this task is not part of healthcare and, most importantly, it is not in the patient's best interest (Sanggaran, Ferguson and Haire, 2014: 377; for France see Chariot, 2010). At question here is the medical personnel's duty of care towards their patients: can healthcare professionals live up to that duty in the context of immigrant detention? Still in the Australian context, Briskman, Zion and Loff explored the risk of what they named medical collusion occurring when physicians have obligations towards state

authorities that might be in conflict with detainees' will and needs (2010: 1097). I further explore these tensions through the case study of midwives' involvement in processes pertaining to migration control in Mayotte.

3. Methodology

This research draws on a three-months ethnographic fieldwork conducted in different hospital sites on the island of Mayotte between mid-April and mid-July 2017. I carried out this research in the framework of the EU Border Care project hosted at the European University Institute (EUI) and funded by the European Research Council (ERC). This research involved sociologists and anthropologists carrying out qualitative fieldwork in various European borderlands around the politics of maternity care for undocumented patients. The project was reviewed by the institutional review boards of the funding body, the ERC and of the EUI, the host university. This particular research was further authorized by the direction of the Mayotte hospital responsible for all hospital sites on the island. My fieldwork entailed interviews with midwives and healthcare assistants in various maternity wards of the hospital, which is composed of a main maternity ward in the capital city Mamoudzou and four regional annexes that include a maternity speciality. Once authorized, the research project was announced per email to the different maternity wards and I started conducting interviews, adapting the interview schedule to the personnel's availability, with interviews lasting from two to four hours with several interruptions. Overall, I was able to interview 40 healthcare professionals in perinatal health services and 15 officers working for stakeholder organizations, from local and international NGOs to health institutions. The interview grid revolved around healthcare workers' daily experiences, exploring their practice of midwifery/care in Mayotte, their relations to patients, their perceptions of the work and social environments, and their

professional trajectories. This article draws in particular on interviews with the medical team that was required to attend to migrant women intercepted at sea by the police, i.e. interviews with 12 midwives and 7 healthcare assistants, as only a minority of healthcare professionals on the island were involved in this process. All research participants provided their informed consent further to a written and oral presentation of the study. Several of the interviews were conducted in groups of two midwives, since, on the one hand, this arrangement allowed for longer interviews given the time constraints, and on the other, it facilitated discussions around the theme of 'kwassa consultations', which progressively emerged as an important topic. All interviews with healthcare professionals were conducted in French, recorded and transcribed. This data was coded using NVivo and I translated into English the quotes that appear in this article.

Given that the medical teams working outside the main hospital, in what are called its 'annexes', are rather small, I do not provide any individualized information about the midwives and healthcare assistants I have interviewed, in order to protect their anonymity. It is important nevertheless to describe these groups of professionals as to their collective characteristics. All midwives interviewed came from metropolitan France. Most of them were young and had recently graduated from their course of study. Several elements accounted for Mayotte's attractiveness in their eyes. As is the case in most French overseas territories, civil servants' earnings at the hospital were significantly increased: for employees of the Mayotte hospital, by approximatively 40%. To add to this, at the time of my fieldwork, the labour market for midwives in metropolitan France was rather saturated, offering few job openings. Finally, a longing for travel and humanitarian experiences also motivated many of these young professionals who were able to combine in Mayotte a well-paid job with a backpacker experience. Similarly to metropolitan healthcare workers in French Guiana (Carde, 2010), these young midwives shared a sense of foreignness in Mayotte and few considered settling

down. As a result of these factors, most midwives stayed in Mayotte for a year or two, generating a very high turnover rate.

In contrast, the healthcare assistants I met were all French Mahorans, some of whom had previously studied and worked in metropolitan France. They completed a one-year training and assisted the midwives with care-related tasks (e.g. bathing babies, preparing beds, distributing meals). All had at least several years of experience; some had worked in different hospital sites in Mayotte for their whole working lives. Midwives relied on them for translation, which could create some tensions since this added to their workload while not being part of their formal duties. Owing to linguistic and cultural factors, midwives and healthcare assistants thus found themselves in different positions within care relationships. Healthcare assistants were not directly involved in decision-making during the 'kwassa consultations', yet they assisted the midwives and were often solicited for translation. This small maternity ward was run entirely by midwives, but if needed an obstetrician's advice could be sought over the phone or a practitioner's opinion among the doctors working in the ward situated next door.

4. The role of midwives within the deportation regime of a French border

The biopolitical governmentality of populations that characterizes the modern liberal state (Foucault, 1976/2003) necessarily results in a growing involvement of medical professionals in the governance of migration. Yet, as a product of sovereign power, biopolitics distinguishes between citizens and non-citizens. Rather than the optimization of health and well-being, I argue that the involvement of healthcare professionals within spaces of migration control responds to the need for minimal biopolitics (Redfield, 2005) inherent in the workings of migration management under liberal rule. In the process, healthcare

professionals become invested with a power to police patients' mobility that challenges medical ethics. In addition to the principles mentioned in the previous section, the deontological code of midwives in France is relevant to the situations studied here. Though French midwives had historically limited medical prerogatives (Jacques, 2007), their status as medical personnel in the hospital was acknowledged in 2014 (Le Dû, 2019). Regarding patients deprived of liberty (either in prison or immigration detention), midwives are requested to report to the judicial authorities if a patient is not receiving adequate healthcare or has suffered ill-treatment. This duty to report ensues from midwives' professional independence, a principle asserted numerous times in the code. It states in particular that being related to any organization by a contract of employment, be it an administration or a private institution, should not affect the independence of midwives' decisions. It further clarifies: 'Under no circumstances may the midwife accept from her employer any limitation to her professional independence. Wherever she practices, she must always act primarily in the interest of the health and safety of her patients and newborns' (Ordre des Sages-Femmes, N.A., my translation). Yet, how can such general principles translate in the complex contexts of migration control and detention? I attempt here to examine how these extraordinary care settings affect midwives' practices and, potentially, their independence.

Acutely aware of the implications of their medical decisions, midwives conducting the 'kwassa consultations' in Mayotte emphasized the absence of any guidance, medical or institutional, on how to determine whether or not the patient should be delivered a certificate asserting compatibility with detention.

> M [Midwife]1: We're supposed to keep them…when they approach the end of the pregnancy or if they have a pathology for which they are likely to be taken care of specifically in Mayotte.
>
> M2: Knowing that no one decided that and that we're the ones doing this.
>
> M1: So, it's just mentioned like that and you're on your own.

'Newer' midwives (a couple of months of work placed a midwife among the experienced ones given the high turnover rate) were familiarized by colleagues with the informal cutting-off date of 32 weeks of pregnancy. More experienced midwives explained to their colleagues that the health state of a pregnant woman should not be deemed compatible with detention from 32 weeks of pregnancy onwards; conversely it was regarded as compatible before that stage of pregnancy if no specific medical condition was found during clinical examination:

> If everything is fine, we can send them back to the detention Centre. If there's a problem, in that case, we keep them here. There's no legislation that defines at what week of the pregnancy we're supposed to keep them. When I arrived here I was told beyond 32 weeks we keep the patients but there's no text that defines it clearly.

The midwives I met in Mayotte deplored this unwelcome responsibility and most felt uncomfortable with their role in the deportation process, something that usually they had not experienced in their previous professional life. One of them lamented: 'It bothers us, this responsibility; it's heavy actually because it's not supposed to be our responsibility'. Yet, it is not uncommon for medical personnel involved within spaces of migration control to be invested with the power to decide whether a detainee should be released on medical grounds, a prerogative they tend to find embarrassing (Enjorlas, 2009: 86). The decision-making power

granted to medical personnel produces life-changing consequences for their patients; yet are these far-reaching implications part of the medical assessment? During the rest of the day these midwives attend to other patients who, to a large extent, are also undocumented women, yet as they are not immediately threatened with deportation the consultation unfolds as usual, with the administrative status having no bearing on the interaction. The unease created by the implications of this medical expertise was palpable in the institutional reluctance to accept any kind of regulation. One midwife explained:

> M1: They [the hierarchy] say it's really up to you; if at 12 weeks, you don't want to send her back, well, don't send her back, there's no legislation, there's no protocol. We said, "Well, it'd be good to have a protocol." Just so we're covered by the hospital because at the end of the day...
>
> M2: Doctors don't want to.
>
> (…)
>
> M1: They all wash their hands of it actually. That's not their problem.

It is not clear how this rule of 32 weeks originated, but there certainly was an institutional will to maintain its informal nature, as a sort of practical norm (de Sardan, 2010) determined by the local professional culture (de Sardan, 2001), which had emerged through local adjustments to specific challenges. Informality facilitated things for the hospital more than for the midwives, as the absence of protocol dissolved the question of responsibility, maintained these practices relatively hidden from view, and left midwives at risk of potential accusations of wrongdoing. As midwives felt left alone at the forefront of difficult medical decisions, precisely because the decisions weren't only medical, the institutional silence attested, between the lines, to the impossibility of care in these circumstances. In the context of

migration control, the authority of the state becomes much more palpable than in more habitual care settings. Though the consultations were taking place on the premises of the maternity ward and not inside the detention centre, the police accompanied the patient and waited at the door to the consultation room. One midwife described the situation it created:

> There are tricky situations sometimes, and then we're pressurized by the police who want to leave quickly, so it's a bit stressful sometimes.

Healthcare professionals' independence was thus affected by the proximity of police authority that governs migrants' bodies right outside the consultation room. Midwives' quotidian work appeared to be eroded by the configuration of power in which they practised.

5. Ethical dilemmas, emotional distancing and undermined relations of care

In this section I explore the terms used by the midwives to frame the ethical dilemmas at hand and foreground the role of emotional distancing in their relations to these extraordinary patients. Ethical dilemmas are intrinsic to medical practice, as many studies in medical anthropology have explored (see for instance Paillet, 2000; 2007 on doctors and nurses' different ethical positions regarding neonatal resuscitation). What makes the ethical dilemmas at hand specific is that they are engendered by a field of policies outside the realm of healthcare, that of migration management. By exacerbating the asymmetrical power relations that characterize doctor-patient relations across the board (see for instance Fainzang, 2006), the intrusion of migration control raises the question of an impossible care.

How is care understood under such circumstances and what is debated as constituting appropriate caretaking? Discussions around the informal criteria to be applied to the medical examination are a good place to start. With the implications of their medical assessment unavoidably apparent to them, midwives did not hesitate to emphasize the arbitrariness of the informal 32 weeks of pregnancy rule. 'Why not 25 weeks? Well, 24, the limit for the foetus's viability?' asked one of the midwives. When challenged by her colleague who considered that there was no specific risk at that stage of the pregnancy, the midwife countered 'Yes, but precisely, the main pathologies arrive in the second and third trimester'. Clearly, there existed an internal debate as to the relevance and adequacy of the unofficial 32-week rule. Though most midwives accepted the rationale in terms of risk evaluation, some were not convinced that having a cut-off date was appropriate:

> We talk about it a lot because often it does raise questions for certain women that we send back to the detention centre and who are at an advanced stage of their pregnancy. At 30 or 31 weeks, it's quite advanced, so we think about it together to know what we do, whether we keep her or not. It's not always obvious, it's not black or white, so we talk about it often.

While the rightfulness of these medical decisions was discussed, few questioned the assumptions underlying the 'fit-for-detention', i.e. deportable, rationale of their medical assessment. Decisions tended to be discussed and gauged as to their clinical relevance rather than more broadly in terms of their ethics. While emotional distancing plays out in any healthcare settings (Fainzang, 2006; Druhle, 2000), here it had a prominent role in facilitating the decision-making process. Consultations were short, taking place with the police waiting at the door, and importantly often with the help of a healthcare assistant acting as interpreter.

The lack of 'social proximity' (Willen and Cook, 2016) between the young White metropolitan midwives and the Comorian women, exacerbated by the language barrier, laid the ground for emotional distancing, as opposed to a dominant norm of empathic care (Charitou et al., 2019). Midwifery emphasizes social relations and empathy as part of the midwife's professional identity (Schweyer, 1996; Jacques, 2007). Yet the context of care encountered in the 'kwassa consultations' could not live up to these standards of care and the language barrier contributed to this. While the need for professional interpretation during the care interaction is increasingly acknowledged in France, the means on the ground tend to be absent (Pian, Hoyez and Tersigni, 2018). In the postcolonial Mahoran context, a minimal form of communication, navigating between midwives' basic skills in Mahoran and patients' limited knowledge of French, was often a necessity. Dealing with this uncomfortable power lying in their hands, many midwives seemed to have withdrawn from engaging much with the patient. One midwife came to the conclusion: 'I'm really getting into that dynamic to protect myself emotionally.' It appeared to be 'easier' to make 'technical' decisions and to limit interactions with these problematic patients, who were inclined to plead their cases and to seek an emotional connection with the midwife.

> M1: It's true that humanly at the beginning it's complicated because you want to do things well, to be humane and kind.
>
> M2: And progressively we'll end up being inhumane, antisocial…and we don't like what we become.
>
> M1: Yes, that's a bit like that, sometimes you send them off a little bit dry: "You're going back, that's it" and you say: "But what am I... what am I? What am I doing? What are you becoming?" But in the end, it's a way to protect yourself as well... The 15 years old pregnant kid, well not too pregnant, but still: "Please ma'am, help me stay

> because all my family is here." Well yes, it's heartbreaking but I have no medical reason to keep you, so how do you want me to do that? So yes, not comfortable…

This quote illustrates how the midwives needed to shut down some of their emotions to make their practice bearable. Several voiced their feeling of becoming 'inhumane', reasserting the need for a distanced approach to the 'kwassa patient'. The following quote narrates how distancing developed by building upon growing suspicions of patients' claims:

> In terms of relations, it's complicated, because at first when I arrived, I struggled with this a lot because I had a lot, a lot of empathy. I had a hard time sending them back to the detention centre. As time passed by, I took a step back and I told myself that we couldn't keep everyone, so I try to put some distance, I stay really professional so that I don't feel sorry and keep her. It's not easy because often they pretend; they invent some symptoms to be able to stay. (…) They beg us; they lie down on the floor. So, it's not easy to manage. But then after a while, with experience, we manage to put a distance and then to explain to the lady "Well, listen, at the level of the examination I have nothing, I can't keep you".

Because of what was at stake for the patients within these interactions, and because of the power of midwives over their patients' lives beyond medical matters, these situations encompassed more than medical interactions. Obviously, this power that midwives were invested with appeared equally clear to the patients, as the previous two quotes demonstrate. The care relation was rendered additionally impossible because these patients were not in a position in which they could trust medical personnel, in view of the high probability that they would be sent back (see following section for percentages), and they certainly did not

consider detention and forced return to be in their best interest. Suspicion on both sides came to characterize these relationships. This intrusion of suspicion in the care interaction was also encountered in other medical settings in which the role of doctors became entangled with that of migration control. Others argued that by becoming part of the decision-making process for health-related residency permits, doctors felt compelled to reproduce the suspicion of public authorities towards migrants (Zeroug-Vial, Chambon and Fouche, 2015). Migrants' rights NGOs contended in this regard that a medical appointment held at the medical service of the French Office of Immigration was more akin to a police interrogation than to a doctor's consultation (Fraysse et al., 2019). In Mayotte, a midwife pondered: 'It's true that during interrogation they always find something that's wrong. And it's up to us to weigh things up during examination, and this is very complicated'. The word used in French during the interview, '*interrogatoire*', is not usually used in the context of care but rather in relation to the notion of 'police interrogation'. The chosen vocabulary is symptomatic of the blurring of roles between healthcare professionals and state authorities in this border management context. As noted by Estelle d'Halluin in the context of medical certificates attached to asylum applications, the lack of time during medical consultations plus a sense of urgency creates the conditions for intense questioning, aimed at establishing facts (2006: 116-117). Offshore detention in Australia produced similar dynamics: 'patients were also cognisant of the dual-loyalty conflict in which nurses were caught, which contributed to mistrust between patient and care provider' (Zion, Briskman and Loff, 2009: 548).

Interestingly, and in spite of not taking these decisions themselves, healthcare assistants adopted contrasting stances as to the role of midwives in the determination of patients' migratory fate. As depicted above, while all midwives were White and came from metropolitan France, all healthcare assistants were Black and Mahoran (including persons of mixed origin from the Comoros and Madagascar), and some had studied and lived in

metropolitan France. Healthcare assistants' positions oscillated between empathy and a marked opposition to Comorian women's presence in Mayotte that engendered judgements as to how their health situation should be assessed. Indeed, several of the Mahoran healthcare assistants believed that midwives had a professional duty to return pregnant women to the detention centre, as long as they did not present any obvious pathology, so that the least possible number of women would be allowed to stay in Mayotte. A Mahoran healthcare assistant stated, during a group discussion with two midwives:

> If you see that there's a little something, you have a doubt, well you keep her, but you don't say yes and find a way [to keep her]. Even lying or finding a way so that the woman stays because you don't want her to be sent back. I tell you I don't agree with this.

In another French overseas department, Guiana in South America, social security administrators, hoping to limit immigration overall through more restrictive access to healthcare, only enrolled undocumented migrants with pressing healthcare needs into the State medical coverage, although any undocumented person in France (yet the scheme does not apply in Mayotte) is theoretically entitled to it after three months of residency (Carde, 2010; Carde, 2012a). In Mayotte, against the background of a widespread anti-immigration political discourse sustained by Mahoran elites (Hachimi Alaoui, Lemercier et Palomares, 2013), Mahoran healthcare professionals were particularly inclined to adopt a minimalistic approach to pregnant women's medical assessment, their view being that possible risks during detention and deportation should play no part in the assessment as long as there was no imminent risk to health found during the consultation itself. While in the past it was the lack of means invested by the French state and the negligence of metropolitan healthcare professionals that crystallized Mahorans' complaints, since the 1990s the figure of the

Comorian migrant has come to be portrayed as the cause of unsatisfactory healthcare provision (Sakoyan, 2012). As a matter of fact, medical personnel are exposed to the politicization of migration issues (Fassin, 2001) and in the context of Mayotte these opinions are strongly polarized. For that matter, pregnant women are regarded particularly unfavourably, as intentions of settlement are presumed and stigmatized, so much so that French citizenship laws were revised in 2018 to add a requirement, that only applies in Mayotte, of legal residence for the parents at the time of the birth, which now conditions the future potential claim of the child to French citizenship once a teenager (Duflo, 2019).

In contrast, others opposed deportation on the basis of their empathy for these patients:

> We don’t know what to do anymore; we feel sorry for them. Especially boarding a kwassa with a pregnancy, I don't know how many hours they spend at sea, but when they get here, they're tired, they're sick, (…) they didn’t choose, it’s misery, we feel sorry for them. I find that it’s fair to welcome them, that’s all.

Healthcare assistants found themselves in a significantly different position from midwives in that they were able to communicate directly with the patients. One of them recounted how the shipwreck of a patient who had arrived earlier that day affected her:

> Some of them can swim, they've been swimming. And she said, there were some young people who could swim, who held her hand, who pulled her with her little one. Some of them carried her baby until they found a little object which was in the sea. They held onto it and they went forward little by little, until the police arrived.
> (…)

> I saw, she [the midwife] has sent her back, she gave the papers to the police, he got her and then she left. We didn't have time to talk. And I felt sorry to see this, that she was leaving, I didn't want to look. Because for sure she will cry, she was already sad when she was told she had to leave. I didn't go close to her, I left the midwife taking care of her. And I came back here. It's a little sad.

Testimonies by healthcare assistants engaging emotionally with women arrested by the police at sea support the analysis that, conversely, the difficult communication between midwives and patients facilitated emotional distancing. Personal stories, from family circumstances to survival of shipwrecks, were only shared with healthcare assistants, when the latter were willing to listen. The healthcare assistant who heard the shipwreck story did not want to be present when the woman was being sent to detention on the basis of the midwife's medical assessment. The midwife in turn might not have been aware that her patient had just survived a shipwreck, as most patients accompanied by the police are soaked because of the crossing that takes place in overcrowded small fishing boats, regardless of a possible shipwreck. While hearing patients' stories individualized their fates in the eyes of this healthcare assistant, not knowing these circumstances might have facilitated midwives' detachment and their limited engagement with this specific category of patients.

6. The normalization of migration control's inroads into care relations

Most midwives' testimonies foregrounded a sense of progressive conformity to the expected medical expertise in relation to the 'kwassa consultations': one that is strictly medical, rather restrictive, and detached from the broader context in which it takes place. This section aims at unpacking how midwives' involvement in migration control became routinized and how a

minimal version of care came to prevail. Midwives' narratives indicated a gradual socialization into a certain practice of the medical assessment of patients at risk of deportation, one that detached care from the broader process of migration control and claimed to be objective. The implications of the medical examination were discarded as irrelevant to the medical expertise, understood as limited to a series of clinical indicators. And yet, this resulted from a process rather than a fixed disposition: nearly all the midwives I met described the importance of colleagues' support in coming to terms with a less empathetic consideration of their patients. The Australian psychiatrist Michael Dudley warns against the 'psychic numbing and denial' (2016: 16) that plays its part within healthcare professionals' involvement in the contemporary Australian detention apparatus. In Mayotte, the minimalist version of care that was implemented relied on collective forms of distancing, in other words on a gradual socialization into the workings of the repressive migration regime:

> I was discussing this with a colleague; she was telling me "me at the beginning", when she started working here "I found any micro-excuse to keep them", out of compassion. (…) She's been working here for two years, now she manages to send back on the basis of the criteria upon which we agreed. So you see now she manages to do it but at first she was saying "I couldn't do it".

Somewhat paradoxically, the community of colleagues did provide a space to discuss medical ethics, but the outcome was a collective reinforcement of the strictest possible approach rather than one rooted in strong empathy for their patients. A parallel can be drawn here with the attitudes of doctors towards the certificates that serve to sustain an asylum seeker's application: Didier Fassin et Estelle d'Halluin observed an increasingly distanced assessment of the patient's medical condition over time, with doctors no longer claiming that they

believed the patient regarding claims of ill-treatment and torture, but simply affirming a probability (2005: 605). The following conversation between two midwives illustrates how this socialization unfolded in Mayotte:

> M1: You learn little by little with the help of your colleagues to remain as objective as possible and to rely only on your clinical and obstetrical examination.
> M2: You're hiding behind your clinical exam?
> M1: Well, yes, to remain…
> M2: I'm teasing you, just teasing.
> M1: Yeah, just to remain objective because otherwise, well if you take them with too much empathy, for sure you would accept everyone.

In his study of doctors' role in issuing residency permits on medical grounds, Fassin observed three attitudes: one that consisted of limiting favourable medical opinions, public health doctors positioning themselves as state-employed civil servants first and foremost; another that involved supporting virtually all medical cases, thus putting into practice the conviction that doctors should not negatively impact one's migration rights; and a third way that consisted of generously assessing patients' situations yet still following a case-by-case logic rather than a positive prior opinion (2001:17). Strikingly, the team of midwives in Mayotte did not experience such distinct positions despite the possibility of doing so in the absence of any formal protocol. Even in the strongly repressive border management context of Australia, it appears that some staff resisted this environment with particularly benevolent consideration towards detained asylum seekers (Briskman, Zion and Loff, 2010: 1101) and the performance of subversive actions to their benefit (Briskman, Zion and Loff, 2012: 42-43). Neither did midwives in Mayotte experience the positionality encountered by Nicolas Fischer in his

ethnography of a detention centre in metropolitan France, whereby doctors' professional ethos brought them closer to migrants' rights NGO lawyers than to the police (2013: 1173). After several months of practice, the initial empathetic stance of many midwives tended to be superseded by a dominant norm of distanced examination, imposed through gentle peer-pressure as narrated by the midwives. The clinical expertise entailed basic medical procedures completed rather hastily so that these additional consultations did not disrupt too much the schedule of the working day. Indeed, hospital archives that I was able to compile during my stay indicate that in 2015, across a total of 238 'kwassa consultations', in almost half of the cases (49,5%), the health situation of the pregnant woman intercepted at sea was deemed compatible with detention. Equally, in 2016, across a total of 154 such consultations, 57,1% of the women were sent to the detention centre. It follows from these figures that the medical consultation did not protect pregnant women from being deported. In fact, owing to the risk assessment frame to which most midwives adhered, their ethical concerns lay mostly with their legal responsibility as medical professionals. Similarly to the point made in the introductory quote, one midwife recounted:

> There was once a nurse who would have, because well I never met that girl, but who would have lost her diploma because there was a child who was in her mother's arms and we don't know if he had died before, during the kwassa [journey] or if he died at the CRA [detention centre]. Anyway, she didn't examine the child and it turned out that the child died and the family in Mayotte filed a complaint.

The fear of risking one's diploma by applying strict criteria in their assessment of pregnant women's health complicates even further the logic underlying midwives' practices: why wouldn't they adopt a more 'generous' stance, as some doctors in Fassin's study did, if on top

of the emotional cost they also feared for their diploma when applying the 'agreed criteria', as one of the midwives put it? The socialization by the repressive regime seems to play a significant role in this process. As White and metropolitan, and employed by the state, midwives could feel particularly close to French state authorities, and to their role in border enforcement as well. The principle of beneficence towards patients can indeed be particularly challenged in postcolonial care settings (Braude, 2009). Of the lives of their patients, the overwhelming majority of whom were either Black Mahoran or Black Comorian women, midwives knew relatively little. Their spaces of socialization included mostly other metropolitan French civil servants, while the high turnover of healthcare professionals limited local integration. Going back to Enjolras' ethnography, he met in a French detention centre a nurse particularly empathetic to the task carried out by the police, viewing health services as also serving to alleviate the police's responsibilities (2009: 82). In the postcolonial context of Mayotte, the similar sociological characteristics of civil servants arriving from metropolitan France, though pertaining to different professions, paves the way for an easy identification between police and healthcare professionals. Briskman, Zion and Loff write about 'the troubling collusion that pervaded much professional activity in immigration detention settings' (2012: 48). They analyse this collusion as resulting from a 'dual loyalty' problem that they define in a previous publication as occurring in situations in which 'the health professional acts to support the interests of the state or other entity instead of those of the individual in a manner that violates the human rights of the individual' (Zion, Briskman and Loff, 2009: 547-548). Echoing this reading, midwives' involvement in the process of migration control in Mayotte necessarily created conflicting duties, as the presence of the police, waiting for the patient on the premises of the maternity ward, enforced a certain duty towards the state, debilitating midwives' independence and endangering their duty of care

towards their patients. The repressive migration regime thus operated a form of socialization of midwives into the rationale of border enforcement.

Conclusion: Questioning healthcare professionals' independence in contexts of migration control

Borders and immigrant detentions are contemporary sites where medical ethics are particularly challenged. With the growing militarization and so-called securitization of borders (De Genova, 2017) on the one hand and the emergence of the suffering body as an object of migration policy (Fassin, 2001; Ticktin, 2011) on the other, healthcare professionals came to play an increasing role in the biopolitical management of migrants' mobility. Despite its particularities, this case study – of midwives' involvement in the decision-making processes leading up to pregnant women's deportation from the French department of Mayotte to the Union of the Comoros – raises key questions regarding the practice of medical personnel in contexts of migration control.

The article demonstrated that it is extremely difficult to preserve midwives' independence, for a series of reasons that reinforce each other. There is the tangible presence of state authorities, here strikingly embodied by policemen waiting at the door of the maternity ward, but there is also the broader politicization of migration issues and specific social positions that sustain conflicting perceptions of migrant patients. Then, the lack of time produces interactions resembling investigative interrogation rather than care. Finally, the lack of social proximity and the language barrier exacerbate the clout of suspicion and undermine feelings of empathy. The studies referenced in this article, as well as this research, indicate that migration policies are making an increasing number of inroads into healthcare. Further enquiry into the ethics of

medical personnel's involvement in processes of migration control is needed, and notably, research into migrants' perceptions of these interactions. This article has aimed at contributing to a conversation around medical practice and ethics within migration governance. The development of institutionalized spaces for discussing medical ethics at the crossroads of healthcare provision and migration policies can be a first step towards thinking about healthcare professionals' independence rather than taking it for granted, with the risk of instrumentalizing medical professions for purposes of migration management.

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