Contradictions and Dilemmas Within the Practice of Immigration Medicine

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ABSTRACT

OBJECTIVES: To identify, explore and critique features of how practices associated with immigration medicine are socially organized. Specifically, how the work of designated medical practitioners (DMP) – physicians who conduct immigration medical examinations of prospective immigrants to Canada as contractors to the Canadian government department of Citizenship and Immigration Canada – is organized to occur in interactions with applicants who are diagnosed with the human immunodeficiency virus during the immigration medical examination.

METHODS: Findings from a theoretically informed empirical study using institutional and political activist ethnography inform this article. Data collection and analytic activities spanning 18 months included observational work in institutional settings, textual review, 61 interviews, and 2 focus groups in three Canadian cities.

RESULTS: The medical examination of prospective immigrants to Canada is not organized as a therapeutic relation of care and has little to do with medicine per se. The rationale structuring the work of DMPs is actually administrative responsibilities. The work achieved by the DMP positions her/him as a key figure and important decision-maker within the Canadian immigration system.

CONCLUSION: The work of doctors who practice immigration medicine gives rise to contradictions and ethical problems. These are largely unresolvable because of the way in which the labour process in which the DMP is implicated is coordinated. The social organization of immigration doctoring practices has serious consequences for prospective immigrants to Canada, for doctors themselves, and for the Canadian immigration system more broadly.

KEY WORDS: Critical methods; designated medical practitioners; HIV/AIDS; immigration medical examination; immigration medicine; mandatory HIV screening; sociology

La traduction du résumé se trouve à la fin de l'article.

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The work carried out by health providers such as doctors, nurses, and social workers who practice what is often interchangeably called bureaucratic, company, corporate, industrial, or occupational medicine in locations both *inside* and *outside* of the formal health care system in Canada has been under-examined by health and social science researchers. Much critical analysis of the organization, relations, and implications of professional practices in institutional contexts such as industry and government medical examinations in Canada dates from the 1980s.¹⁻⁴ These empirical studies identify and examine the politics, conflicts, and competing loyalties embedded in the coordination of doctors' work, noting how these arrangements affect patients, front-line workers, union representatives, corporate owners, and physicians themselves.

This article contributes to and extends this vein of critical inquiry into the relations governing doctoring work taking place in opaque and bureaucratic settings that are outside the daily experience of most of us. The term *immigration medicine* is coined to refer to specific relations of care and institutional practices enacted between immigrant applicants to Canada and designated medical practitioners (DMP), physicians authorized and hired by the Canadian government to conduct immigration medical examinations (IME) of prospective immigrants in institutional offices both in Canada and overseas. DMPs practicing in Canada occupy a unique, intriguing, and complex social location that is at once *inside* and *outside* of the

formal health care system. Prior to this study, DMP work had never been the focus of critical inquiry.

This analysis opens up for critical investigation previously unexplored and undocumented features organizing the professional work practices that occur (or not) within the Canadian IME when prospective immigrants are diagnosed with the human immunodeficiency virus (HIV). The argument is that the medical examination of prospective immigrants to Canada has little to do with medicine per se. In this way, the practice of immigration medicine, and the figure and function of the DMP, involve relations that are more troublesome and internally fractious than might initially be expected.

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METHODS

Herein I report findings emerging from an interdisciplinary, theoretically informed empirical exploration and critique of the organization of the Canadian immigration system, with particular emphasis on the social organization of medical in/admissibility.⁵ The practices associated with and consequences of mandatory HIV screening of immigrant and refugee applicants for Canadian permanent residence within this institutional system were examined. Results show that the Canadian state's ideological work related to the HIV policy and mandatory screening ushers in a set of institutional practices that are highly problematic. Among other outcomes, this study produced an important corrective to the official and quasi-official claims about practices and procedures said to be happening in relation to Canadian immigration HIV screening. Ethics approval was obtained from the University of Ottawa, and standards in Canada's Tri-Council policy statement on research practice were rigorously respected.

This study was an institutional and political activist ethnography and is the first social science analysis of the inner working of the medico-administrative practices regulating Canada's immigration process.⁶⁻⁸ These forms of ethnography are sociological approaches that share common ancestral, epistemological, ontological, and theoretical lineage within an anti-positivist paradigm. They draw on Marxist and feminist theorizing to provide a research starting point within the material features of people's lives and from a clearly articulated social position. How people use texts such as print, film, photographs, and mass and electronic media is studied because texts provide the standardizing messages, categories, and concepts for how and what we know. The reproduction and circulation of texts is analytically investigated because these practices are key organizers of how people are regulated. Understanding of textual media as coordinating people's practices distinguishes institutional and political activist ethnography from other ethnographic forms.

Social inquiries using institutional and political activist ethnography explicate the organizational processes and make explicit relations that govern people in contemporary societies. The state, professional bodies, corporations, the academy, and science are involved in a web of relations through which ruling is achieved. Inquiries proceed from the acknowledgement that social life is marked by deeply structured inequities that are "contingent features of human organization".⁹ In so doing, findings provide a scientific basis from which people can work to redress inequities. This sort of inquiry yields "formal, empirically based scholarly"¹⁰ explanations of how the social world is organized. These are useful for public health practice and policy because results produce rich descriptions of happenings *on the ground*, and analyses point to specific, rather than general, places where reform is needed. In recent years, social and health scientists in Canada and elsewhere have used these forms of critical inquiry to investigate a range of organizational processes and socially organized problems, and findings have provided evidence-informed recommendations for progressive policy and legal change.¹¹⁻¹³

Fieldwork

Data were collected during two sequential tranches of fieldwork spanning 18 months. The first of these involved interviews and focus groups with 32 successful applicants for permanent resident

status and 1 successful applicant for temporary residence. They were, for the most part, resident in Toronto and Montreal, and fieldwork occurred between fall 2009 and winter 2010. All informants had undergone mandatory screening for HIV for immigration purposes. Informants were recruited through notices posted in AIDS service organizations and HIV clinics, on listservs, and by word of mouth. Twenty-nine informants were HIV-positive and 4 were HIV-negative. Informants were citizens of 22 countries, and in-person interviews from between 60 to 120 minutes in length were conducted in English and French, and through interpretation in Amharic, Cantonese, Mandarin, and Mongolian.

Interview dialogue was organized around the activities in which people living with HIV engage to immigrate to Canada. I learned about the complexities experienced during immigration as shaped by a diagnosis with HIV. The problematic organizing this inquiry was the difficulties that prospective immigrants with HIV face as a result of state-sanctioned practices occurring (or not) when diagnosed during the IME. Information from a large number of people about a variety of HIV screening experiences was collected because I was interested to know *whether* and *how* these experiences were organized differently because of where in the world a person's Canadian immigration HIV screening had been performed. Through informants' descriptions of the activities stemming from their immigration process, and the texts used for this purpose, I gathered understandings about the intersections between the work that was required of them to immigrate and the work of a wide range of people variously implicated in formal and informal ways in the Canadian immigration system. I approached the latter people during a second stage of fieldwork.

Second-phase data were gathered in 28 bilingual (English, French) interviews in Toronto, Montreal and Ottawa from winter 2010 to summer 2011. I conducted interviews with lawyers, DMPs, HIV physicians, social workers, nurses, AIDS service organization case workers, housing shelter personnel, public health authorities, Canadian Border Services Agency personnel, and current and past Citizenship and Immigration Canada (CIC) employees. Informants were directly recruited using snowball sampling and my personal knowledge as participant in the Canadian HIV organizational, health care, and research milieu. In-person interviews were approximately 60 minutes in duration. They occurred within informant workplaces: hospital lunchrooms, conference rooms, and individual offices, among other institutional locations. Dialogue centred on informants' work related to and stemming from Canadian immigration medical policy and law. I also carried out observations in various institutional settings including privately operated immigration medical clinics, immigration hearing rooms, and CIC offices. While in these locations, I paid close ethnographic attention to what was happening there because details about people's practices provided valuable clues about the social organization of the broader institutions of which the immediate workplaces were a part.

Data analysis

Analysis was an iterative and inductive process that began in the first interview and continued through write-up of results. This approach is consistent with existing methodological conventions,^{14,15} where the goal is to build an argument informed by materially occurring practices in institutional settings under examination. I moved through the data to examine taken-for-

Figure 1. Processing of a prospective immigrant's medical file

granted features of people's practices; to consider contradictions and tensions in informants' experience; and to identify clues about the social relations organizing people's practices.

Textual review was carried out on an ongoing basis. I closely considered a variety of texts, including government documents (forms, guidelines, legislation, policies), informant files (identity cards, application and registration forms, medical charts), results from my access to information requests of CIC,¹⁶ among other official texts.¹⁷ Examples of government-issue documents include the Immigration and Refugee Protection Act (IRPA) and Regulations;^{18,19} Canada's HIV Testing Policy;^{20,21} successive editions of DMP handbooks;²² and the Personal Identification Form used by refugee applicants.²³

The process of analysis I engaged in can be loosely described as occurring in four intertwined phases in which I undertook the following activities:

- 1) *listening* to and *transcribing* audio-recordings in English and French;
- 2) *reading* transcriptions and field notes;
- 3) *organizing* the data into four categories according to how informants invoked
 - i) *institutions* with which they interacted,
 - ii) *texts* they used,
 - iii) *people* with whom they associated for immigration purposes, and

iv) *practices* in which they regularly engaged for immigration-related reasons; and,

- 4) *analyzing* and *writing* about the data organized in the manner described.

RESULTS

The DMP is a key actor in the Canadian immigration system because she/he is responsible for medically examining prospective immigrants and for reporting findings to the Health Management Branch of CIC. Three mandatory diagnostic screens are commissioned – HIV, syphilis, and tuberculosis – and additional tests can be ordered at the discretion of the physician. Results of these screens, assembled and submitted by the DMP, are sent to the federal, and in some cases provincial, government. Medical officers internal to CIC stationed in one of the 10 regional medical offices in the world review medical files with problematic results including, but not limited to, an HIV diagnosis.²⁴ From here, officers proceed to hypothetically anticipate costs of publicly funded care for applicants with serious medical conditions. These estimates are key determinants as to whether a person is in/admissible for immigration to Canada.²⁵ In this way, we see that the DMP's labour centrally supports the Canadian immigration program, which is a textually-mediated organization where people's work is connected by the texts they circulate. The positive result of an immigration

HIV screening catalyzes the state's collection of medical data about a prospective immigrant, which are entered as key constituents into state decision-making about the person's in/admissibility to Canada. This internal flow of information relating to the institutional processing of a medical file of an applicant with HIV is illustrated in Figure 1.

Medical examination

The federal government places a great deal of importance on the IME. Applicants to Canada do likewise because they come to realize the government's preference for unproblematic medical screening results. Discussing features of her IME, and drawing attention to when and how it occurred to her that the experience was of pivotal importance in her immigration process, an immigrant informant said,

"They were very strict. The secretary of the doctor [DMP] gave me forms to fill in prior to the blood tests. She glued a picture of my face to a form. The person who drew my blood had to sign, on diagonal, over my face to be sure that they took my blood and not the blood of another person."

The IME is an obligatory and regulated practice under IRPA. Approximately one million and a half IMEs are conducted annually inside and outside of Canada. The Canadian government appoints an estimated 1,000 physicians around the world, most often trained as general practitioners, on a five-year renewable and contractual basis to do IME work. Immigration medical programming and the health of applicant immigrants to Canada fall within the purview of IRPA rather than national health legislation.²⁶ The medical assessment of immigrant applicants, and the vast quantity of guidelines, policies and practices related to this process that are also enacted under IRPA, are key mechanisms by which the state sets out to regulate population and public health in Canada. This includes who is allowed to enter and remain in Canada, and under what conditions persons are authorized to stay. However, CIC relies heavily on input from the Public Health Agency of Canada about matters relating to immigration medical programming, including the regulation of Canadian borders and changes to practices within the IME, such as the addition of mandatory HIV screening in January 2002 as the only regulated change in approximately 50 years.^{27,28} Careful examination of the activities that government employees and contractors such as DMPs engage in in relation to HIV within the immigration program shows that particular notions of contagion, infection, disease transmission, and "risk" inform their work. Certain diseases and disease bearers command greater scrutiny than others, and HIV is one of these conditions. In fact, no other medical condition is subject to the sort of scrutiny that HIV garners within the Canadian immigration system, as measured in the quality and quantity of institutional texts and practices that govern foreign nationals with HIV.

Immigration doctoring practices

Analysis of the material circumstances of the IME, and the social organization and relations governing the work of DMP, reveals that the medical examination of prospective immigrants has little to do with medicine per se. Immigration medicine and the role and function of the DMP in her/his interactions with prospective immigrants living with HIV produce the troubling consequences discussed below.

Administrative

The logic structuring the doctor's IME work is her/his medico-administrative responsibility to the Canadian state. The DMP initiates the paper trail that will be the basis for decision-making about a prospective applicant's medical in/admissibility to Canada. A medical file can thus be seen as more than a report of disease status: it brings into view specific medical conditions, while excluding others, and creates the conceptual boundaries that define an acceptable immigrant. The DMP's IME work is centrally organized around filling out forms, collating documents, arranging diagnostic screens, attesting to the authenticity of the processing of the latter and to the identity of the applicant, and, finally, disclosing findings to federal, and in some cases provincial, government authorities. Said a DMP informant: *"My role is limited. I am a contract worker. My job is paper-based, and it should be that way."*

The DMP quoted here talks about her/his work being organized in particular ways, and s/he is able to rationalize and discuss this in a matter-of-fact way. At the same time, this characterization of DMP function elides the fact that DMPs are routinely face to face with people who experience a variety of hardships, particularly in the case of refugees and refugee applicants to Canada. It is troubling that a physician practising in Canada can understand and articulate her/his professional responsibilities as primarily administrative and "paper-based", and furthermore that "it should be that way", because such responsibilities are not the foremost duties that are supposed to guide physician practice. The eclipsing of care responsibilities by administrative ones is furthermore not what most of us would expect in a visit to a doctor in most circumstances.

The displacement of the DMP's clinical reasoning by medico-administrative duties is problematic. It marks a sharp difference in how this same doctor would, and would be expected to, interact with people who are not immigrants that she/he would see in the course of her/his regular medical practice (that is, people with Canadian permanent resident and citizenship status). In the latter situations, emphasis would be on patient care. In the IME, however, DMP work is informed and governed by the state's concern for public health, safety, and cost according to IRPA. The concept of "risk" centrally shapes the work of DMPs and it also informs the work of other actors whose work is formally and informally associated with the Canadian immigration system. Said a DMP informant,

"The government is concerned with three things: danger to public health, danger to public safety, and excessive demand on health or social services. This is what they want me, as the DMP, to zero in on."

These points make visible that in the particular context of the IME, institutional requirements of creating a medical file that intends the work of medical in/admissibility determination are prioritized over applicants' concerns, including their interest in their personal health and well-being. These social arrangements give rise to a range of tensions and contradictions for immigrants with HIV and for DMPs themselves. These relations also point to ethical problems and inequities embedded within the Canadian immigration program.

Non-therapeutic

The IME is plainly not a therapeutic interaction where a relation of care is established between doctor and patient; a point made in the most recent edition of CIC's Handbook for Designated Medical

Practitioners.²² This resource lists the job description, theoretical framework, and standards of practice that are to guide DMP work, though DMPs interviewed report that it is not among the tools they regularly use. A central role that this text plays is to support the idea that certain standards of medical care and practices happen in the IME when someone is diagnosed with HIV despite empirical evidence to the contrary (e.g., pre- and post-HIV test counselling). CIC's public education about the HIV screening policy and medical in/admissibility process additionally supports the notion that particular forms of care and professional practices systematically take place in the work of DMPs despite conflicting empirical reports.^{29,30} About the organization of this work, a DMP informant said,

"This is totally different than my family practices. Here I am a fact finder; gathering information; giving it to a higher level that has a protocol to make a decision. In sum, we are the guys in the trenches. We do the examination, and the guy in government decides."

Applicants to Canada with HIV do not initially know that the IME is organized in the interests of the state rather than their own interests – that is, toward disease detection that would make them ineligible for immigration, and away from their subjective concerns. Other reports on my research that deal with the consequences of no informed consent to HIV screening and widespread absence of pre- and post-HIV test counselling practices confirm applicants' surprise and disappointment when they uncover the priorities governing the IME.^{30,31} For example, informants with HIV are dismayed that at the time of their diagnosis, first-order messages from DMPs are population- and public- rather than personal-level health concerns. An informant described his interaction with the DMP moments before his diagnosis:

"The first question was, 'Do you have sex with men?' [The DMP] asked me if I was having sex with men in Canada. I said [to myself], 'Oh my God! He is inquiring to see if I am spreading this in Canada.' When he asked me the question about my behaviour – whether I have sex with men – his indirect manner of coming to the point of me being HIV-positive; I knew, without a doubt, that I was HIV-positive."

The applicant quoted above has just learned that he is living with HIV, which he experiences as a moment of cardinal importance. For the DMP, what shapes this interaction is the responsibility to report this person to government(s). To fulfill these reporting requirements, this DMP questions the man about his behaviour and sexual orientation, inquiring about the extent of "risk" associated with him. The doctor investigates and assesses whether this individual has engaged in unprotected sex with men in Canada. By way of information gathering and mandatory form filling, we see how the DMP's work contributes to federal and provincial surveillance and tracking systems organized around HIV-positive immigrants. These institutional mechanisms are catalyzed by a positive HIV result during immigration procedures.

In a perverse construction of medical practice, therefore, the work of the DMP is specifically organized *against* the possibility of being an encounter with a therapeutic or caring purpose. Within people's stories and the materially occurring, observable conditions of the IME is evidence that medical responsibilities and principles from which ethical codes derive – such as confidentiality, do no harm, patient well-being, appropriate care, and informed consent practices³² – are compromised and in some instances breached in the IME. About activities both present and absent during her IME, an immigrant informant said,

"I signed a waiver indicating informed consent. I had no choice but to do an HIV test. If not, I would not have been granted a visa. From a legal point of view, everything is correct because I agreed and signed a document. But, in reality, I did not have a choice but to submit to a test because I wanted to come to Canada. No HIV test, no visa. So I had to do it."

In effect, then, the organization of DMPs' work means that these doctors are called to work in professional and ethical grey areas in their interactions with prospective immigrants. That applicants with HIV report a generalized lack of pre- and post-HIV test counselling practices is not surprising when the social relations such as these that organize the IME are revealed.

Decision-making

DMPs are central and significant decision-makers within the Canadian immigration system since, as explained, their work enables government medical officers to decide about an applicant's medical in/admissibility. Despite their crucial function and contributions to government decision-making, DMPs who participated in this study framed their IME work as "standard", "normal", and "routine". The DMP quoted below emphasizes a hierarchical division of labour, ranking himself as a low-level immigration decision-maker. He said:

"I have a certain job to do, and Ottawa does, as well. I respect this. I have worked for government on many levels before. My job is not to make decisions or pass on opinions to the client. You must be very careful about that. We all work at a certain level."

He and other physicians interviewed actively positioned themselves either at distance from or entirely removed from decision-making roles within the Canadian immigration process. Yet, DMP work directly informs and enables certain forms of government decision-making and rationalities, and this work also embodies and reinforces the authority of the Canadian state – an authority that is further strengthened by the impression of the DMPs' neutrality.³³ Talking about his professional functions, a DMP commented that *"my work is with Immigration; with Ottawa; the federal government, principally. I am otherwise retired."* Another DMP would not take part in this study on the grounds that his immigration medical work was "property of Citizenship and Immigration Canada". From these DMP comments about their work, we understand that doctors' decision-making practices and the duties they carry out during the IME are squarely aligned with and structured by state interests.

CONCLUSION

The analysis offered in this article is not a personal critique of DMPs who are key participants and important decision-makers in the Canadian immigration system. Rather, this article focuses careful analytic attention on the social relations organizing the practice of immigration medicine during the IME, with particular focus on the work of DMPs in their interactions with prospective immigrants to Canada who live with HIV. This analysis makes visible and provides insights into various socially produced problems that are accomplished through the work of DMPs. We see that the IME has above all to do with medico-administrative duties to the state rather than therapeutic relations of care or the responsibility of patient best interest, and that these arrangements lead DMPs to work in contravention of principles guiding medical practice.

The problematic issue of doctors' dual or divided loyalties, including where their work practices are organized in ways other than in the subjective interests of patients, has serious consequences for patients and doctors in institutional settings and public health bureaucracies well beyond the IME (e.g., carceral spaces, nursing homes, psychiatric facilities).³⁴⁻³⁶ The ruling relations that organize DMP work stretch beyond any one immigration medical encounter, which makes the effects that these relations produce generalizable and generalizing in the practices of the estimated 1,000 physicians throughout the world who conduct IMEs for the Canadian government. It remains unclear, however, *whether or how* these relations and the disturbing practices to which these relations give rise can be resolved because of what this study reveals about how the IME work process is organized. Public health practitioners and policy-makers can pause to consider the implications of these social relations, including the dilemmas faced by prospective immigrants who undergo IMEs and the problems with how DMPs are asked to work with these people.

A key feature of the organizing logic of the labour process in which the DMP is implicated is detection of disease and exclusion. This is true of the broad function and purpose of Canadian immigration law, and the mandatory HIV screening policy more specifically. It might be beneficial if, as part of their practices in the IME, DMPs were to make this logic visible by explicitly raising this issue with prospective immigrants; indicating that the examination is neither therapeutic in intent nor organized by their subjective interests. With the intention and purpose of the IME clarified, immigrant applicants could decide to use this knowledge as they wish: perhaps to readjust their expectations of the DMP and the examination, or perhaps as a tonic to diminish the effects of the systematically difficult experiences that immigrants who took part in this study reported about the circumstances and professional practices surrounding their HIV diagnosis by DMPs working in the interests of the state.

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RÉSUMÉ

OBJECTIFS : Identifier, explorer et critiquer l'organisation sociale des pratiques qui relèvent de la médecine de l'immigration. En particulier, comment le travail du médecin désigné – médecins contractuels au département fédéral de Citoyenneté et Immigration Canada chargés de faire l'examen médical aux fins de l'immigration d'immigrants prospectifs – est organisé lors des interactions avec les demandeurs de résidence canadienne ayant reçu un diagnostic de séropositivité au virus d'immunodéficience humaine lors de l'examen médical de l'immigration.

MÉTHODES : Les résultats d'une étude théorico-empirique qui a employé l'ethnographie institutionnelle et l'ethnographie d'activisme politique comme méthodes d'enquête fondent cet article. Les activités de collecte et d'analyse des données ont eu lieu pendant 18 mois et étaient constituées d'observations dans divers lieux institutionnels; d'analyse de textes; 61 entrevues; et 2 groupes de discussion (« focus groups ») dans trois villes canadiennes.

RÉSULTATS : L'examen médical des immigrants prospectifs au Canada n'est pas l'occasion d'une intervention thérapeutique, et a peu de rapport avec la médecine proprement dit. Le raisonnement clinique du médecin désigné est en fait remplacé par des responsabilités administratives. Le travail effectué par ces médecins fait en sorte que cet individu soit une personne clé et un preneur de décision important au sein du système de l'immigration canadien.

CONCLUSION : Les pratiques réalisées par les médecins désignés donnent lieu à des contradictions et problèmes éthiques. Il y a peu de chances à ce que ces derniers soient rectifiés en raison de la manière dont ce médecin est appelé à travailler. L'organisation sociale des pratiques de la médecine de l'immigration a des conséquences sérieuses tant pour les immigrants prospectifs au Canada que pour les médecins eux-mêmes et le système de l'immigration canadien de façon générale.

MOTS CLÉS : dépistage obligatoire pour le VIH; examen médical aux fins de l'immigration; médecine de l'immigration; médecins désignés; méthodes critiques; sociologie; VIH/sida