Governing the Lives of Immigrants: A Foucauldian Perspective on Tuberculosis Immigration Medical Surveillance in Canada

by

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A thesis submitted in conformity with the requirements for the degree of Doctor of Philosophy
Dalla Lana School of Public Health
University of Toronto

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Abstract

This dissertation critically examines the experiences of new Canadian immigrants and immigration applicants undergoing immigration TB health screening and surveillance, and focuses on the social effects of this process on the health and wellbeing of newcomers. Using Foucault’s theoretical framework of governmentality, this study seeks to understand how various knowledges about health and the immigrant body are (re)produced through the articulation of immigration, public health, and biomedical discourses, and how these regimes of knowledge and power constitute social relations and structure the daily reality of newcomers to Canada. The first purpose of this study was to document the ways in which ‘medicalization’ of the immigration process shaped the migratory journeys (i.e. constrained and enabled possibilities for action) of immigration applicants. The second objective was to understand how these overlapping discourses created rationalities of governance to construct and regulate immigrant subjects, and to what effect. Data were generated through semi-structured interviews (15) with newcomers undergoing immigration TB screening and surveillance, observations of immigration TB clinic appointments (14), and observations of the TB clinic itself. The data were analyzed to determine how newcomers navigated the immigration and settlement, and immigration medical surveillance
(IMS) processes, and how they negotiated power during interpersonal encounters with authorities and experts, particularly at the site of the TB clinic. The tensions arising from competing discourses and logics were found to have multiple negative effects: they create structural barriers to obtaining immigration status causing physical, psychological and emotional suffering for applicants; they produce conflicting and perceivably irreconcilable subjectivities for applicants (the ‘desirable’ immigrant vs. the ‘good’ TB patient); and they unwittingly implicate TB health care providers into the mechanism of immigration surveillance as state authorities, corroding the doctor-patient relationship and undermining their ability to provide adequate medical care to newcomers. I argue that an overemphasis on biomedical approaches to treating TB among newcomers in the name of biosecuritization does little for actually controlling TB in Canada. Instead, this study reveals the need to incorporate a social determinants of health approach, particularly one that acknowledged the immigration and settlement process itself as a determinant of TB and immigrant health.
For my Dad
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“And, when you want something, all the universe conspires in helping you to achieve it”

(Coelho, 1993)

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Definitions

CIC: Citizenship and Immigration Canada is the former name of what is currently called Immigration, Refugees and Citizenship Canada (IRCC) (the name was changed in November 2015 after the Liberal Party took office under the party’s leader, Justin Trudeau). CIC/IRCC is a federal department that oversees the Canadian immigration system and deals with matters pertaining to immigration and Canadian citizenship, and provides protection to refugees (CanadaVisa, 2017; CIC, 2017a). Because study data were collected prior to November 2015, I use the former name, CIC, to refer to this federal department throughout this thesis.

Discourse: This term refers to the ways in which language (discursive practices) and actions/relations (non-discursive practices), both social and institutional, create the conditions of possibility for knowledge about a particular phenomenon. This is based on Foucault’s historical analysis of the development of human sciences and medical knowledge, specifically, in The Order of Things and The Archaeology of Knowledge (Smart, 2002, p. 31-32).

High-Income, (Lower and Upper) Middle-Income, and Low-Income Countries: These terms follow the current definitions as per The World Bank (2011a), which classifies countries based on their economic performance measured by gross national income (GNI). While this measure is not indicative of social development, does not take into account national debt, and can mask income inequality and true measures of poverty, I prefer to use this terminology over that proposed by the United Nations. Despite its focus on both economic and social development in its classification system, the United Nations has “no established convention for the designation of ‘developed’ and ‘developing’ countries or areas” (United Nations, 2010), meaning it is a more arbitrary form of classification.

High TB Incidence: The Public Health Agency of Canada considers countries to have a high incidence of TB if the 3-year average incidence rate of sputum smear-positive pulmonary TB is 15/100,000 or greater, as estimated by the World Health Organization (Canadian Tuberculosis Committee [CTC], 2007). Because this is the standard definition used in official policies and guidelines by the Public Health Agency of Canada, it will be used in the same way throughout this study.
**Immigrants:** While TB does not affect one category of newcomers to Canada more than the next, the process of detecting TB infection through the immigration medical examination differs depending on immigrant class. Unless specified otherwise, in this study the term ‘immigrants’ refers to those newcomers who have applied for immigration or obtained permanent resident status through formal channels, and are residing in Canada legally. This includes economic-class and family-class immigrants. Refugees are a particularly vulnerable group with very specific and complex health needs and, as such, are excluded from this definition.

**IRCC:** Immigration, Refugees and Citizenship Canada. For a definition, see ‘CIC’ above.

**Governmentality:** This concept developed by Michel Foucault has been taken up to have several meanings. In this study, I use this concept to refer to the ways in which the control of individuals is accomplished through the “contact between technologies of domination of others and those of the self” (Foucault, 1988, p.19) to achieve a certain end. The ‘government’ of individuals and populations, or in other words the ‘conduct of conduct’ is accomplished through the exercise of a complex network of power “formed by the institutions, procedures, analyses and reflections, [and] the calculations and tactics” in a society (Foucault, 1991a, p.102).

**Poverty:** In this dissertation, I use The World Bank’s (2011b) definition of poverty, which refers to the ration of the population living on less than $2 per day.

**Secondary Prevention:** The definition of secondary prevention used here is that given by Michaels et al. (2008, pp. 586-587), which refers to the screening, testing, and treatment of a condition that is asymptomatic and has not yet developed in order to prevent the future development of disease. Secondary prevention is an important public health strategy for decreasing mortality and morbidity in contemporary societies.

**Settlement:** In this study, ‘settlement’ refers to the period of time after arrival in Canada as a temporary or permanent resident (immigrant). Settlement for newcomers begins at the moment of arrival in Canada and includes the period of time before all conditions of the immigration application (i.e. completion of immigration medical surveillance) confirming the immigration status of newcomers have been met. In this study, I apply the Canadian Council for Refugees (1998, p. 9) definition of settlement as the “acclimatization and the early stages of adaptation, when newcomers make the basic adjustment to life in a new country, including finding
somewhere to live, beginning to learn the local language, getting a job and learning to find their way around an unfamiliar society”.

**Social Determinants of Health:** This framework is used here as an analytical tool which allows for a critical examination of the root causes of TB. This approach considers the influence of social, political and economic structures on the distribution of health and illness in a society and across populations (Raphael, 2004a). More specifically, this approach focuses on the role of power – in the form of access to and control over social and economic resources – as the key determinant of health.

**TB-UP:** Treatment Services for Uninsured Person Program (TB-UP) is a program that covers the cost of outpatient treatments, and diagnostic testing, and medications for tuberculosis (TB) for anyone without adequate health insurance (i.e. OHIP, IFHP, etc.)

**Tuberculosis (TB):** TB is a widely studied infectious disease with a clear biomedical understanding of its pathogenesis, the disease process, clinical features, treatment and complications. While it is very much a ‘real’ disease in a positivist sense, it does not affect all individuals equally. I do not simply consider this inequality to be based on the biomedical explanation of individual physiological risk factors; rather, I adopt the sociological understanding of TB as a biological disease that thrives under conditions of social and economic deprivation.
Abbreviations

BCG – Bacille Calmette-Guerin (BCG) vaccine

CIC – Citizenship and Immigration Canada

DOT – Directly Observed Treatment

IFHP – Interim Federal Health Plan

IGRA – Interferon Gamma Release Assays

IME – Immigration Medical Examination

IMS – Immigration Medical Surveillance

IRCC – Immigration, Refugees and Citizenship Canada

LTBI – Latent Tuberculosis Infection

OHIP – Ontario Health Insurance Plan

PM – Panel Member

PP – Panel Physician

TB – Tuberculosis

TST – Tuberculin Skin Test
Prologue

For many years tuberculosis (TB) has been, and continues to be, a widely studied disease. Much of this work focuses on the clinical aspects of TB, including clinical presentation, diagnosis and treatment. The public health field is most often concerned with the epidemiology as well as the prevention and control of TB, emphasizing individual risk factors and treatment adherence.

While much work on communicable diseases centers around its biomedical aspects, diseases such as TB have serious consequences for the societies in which they exist. Conversely, the social aspects of infectious diseases cannot be ignored as they help to explain the distribution of health and illness in populations. The link between biological health and social existence is therefore a central issue for social health researchers.

The social determinants of health approach has become a useful analytic tool for health researchers to understand the root causes of health inequities, highlighting the role of structural rather than individual risk factors associated with disease. This concept has in recent years become an official position of the World Health Organization (WHO) (Commission on Social Determinants of Health [CSDH], 2008) and has been used to address the problem of TB (Lonnroth et al., 2009; Hargreaves et al., 2011). It is only recently that the WHO has recognized migration itself as a social determinant of TB (WHO, 2014a). While this shift in perspective about (im)migration as an underlying structural cause of TB is finally making its way into research and academia, it remains much less central to official public health guidelines and immigration policy around TB in Canada (Public Health Agency of Canada [PHAC], 2014a, 2014b).

Empirical scientific knowledge, including the ways in which health problems are framed and conceptualized, is used as evidence to inform the policies and practices that help shape the social structures of institutions such as medicine. These knowledges are reproduced through discourses and institutional practices, which consequently shape the actions and social attitudes of individual actors and entire populations. Therefore the scientific knowledge about TB as well as the current public health policies and TB control and prevention strategies are all imbued with social meaning and affect the ways in which individuals with TB lead their lives and understand themselves as subjects of knowledge.
Because immigrants are regarded as a ‘high risk’ population, current TB control strategies in Canada target immigrant populations (PHAC, 2014a, 2014b). Thus the prevailing medical and epidemiological conceptualization of TB is of particular social importance to those individuals. The objective of this study is to investigate the social effects of current TB control strategies on newcomers to Canada in the greater context of migration. More specifically, my goal is to understand the ways in which power operates to govern the ‘diseased bodies’ of immigrants in Canada. This work is significant because it will provide a better understanding of the ways in which current knowledge about TB shapes the social and material reality of immigrants, affecting their overall health and wellbeing.

Although TB is typically constructed as a biological disease, it is also, though less frequently, regarded as a social disease (Farmer, 1997). As a social health researcher, I maintain that a complex disease like TB cannot be adequately addressed without paying attention to the social context in which it exists. I approach this problem from a critical social standpoint and am greatly influenced by the work of Michel Foucault. Because my understanding of TB is situated within the social determinants of health framework, I hope to contribute to the current body of knowledge on the social determinants of immigrant health in Canada.

Because of the diverse and complex nature of TB, this study spans across disciplinary boundaries of social and medical sciences. The main fields of interest to this study are migration, public health and TB prevention, and health care / TB treatment. Thus this work is intended to reach an equally diverse audience, such as the public health community, including front line health care professionals and others working in TB control, as well as researchers working on immigrant health issues in Canada and in a global context. I hope for the results of this study to have practical application in the field of public health to help improve the health, integration and overall wellbeing of newcomers to Canada.
Chapter 1
Background: Situating TB Within the Disciplines

1 Introduction

Although the exact etiology of tuberculosis (TB) was highly debated in the nineteenth- and early twentieth-century, great emphasis used to be placed on the role of social factors (Feldberg, 1995; Reitmanova, 2008). In contrast, the TB of the late twentieth-century is no longer regarded as a social disease but rather has become highly technical and scientific. Today, TB is primarily understood in biomedical terms and categorized strictly as an infectious disease. This definition conceptualizes TB at the molecular level, focusing on the ways in which the pathogen affects human tissue and induces an immunological response in its host (Reitmanova, 2008). Such a perspective removes the individual from their macro-social and environmental context reducing disease to its location within the body where it exists as a biological disorder.

The purpose of this section is to provide a background to the proposed study. Because this work spans across two disciplines, social and medical sciences, I include both perspectives here. I begin by presenting the current biomedical explanation of TB followed by the conceptualization of TB as a social disease. I provide an overview of the global trends of TB, TB in the Canadian context, and situate it within the broad understanding of immigrant health in Canada. Furthermore, I outline the current public health approaches to TB prevention and control in Canada, particularly in the context of migration. I end the chapter with a brief overview of the thesis.

2 TB as a Biomedical Disease

Tuberculosis is an infectious disease caused by the microorganism *Mycobacterium tuberculosis* (*Mtbc*). It is transmitted via the respiratory route through prolonged close contact with an individual who has active pulmonary TB; the bacillus is expelled into the air in the form of aerosols through coughing, sneezing, or speaking and inhaled or ingested by another individual (Bloom, 1994). Once the pathogen enters the body, primary infection occurs with two possible consequences. The infection can become progressive primary disease (active TB that occurs directly as a result of acquiring TB infection), which happens in 5 to 10 percent of cases (Bloom,
In most cases, however (approximately 90 percent) the individual’s immune system is strong enough to prevent the reproduction of the bacillus within the body; an individual develops partial immunity to *Mtb* and the infection remains dormant as a state of equilibrium between the bacillus and the host is achieved and maintained (Flynn & Chan, 2001). This is known as latent TB infection (LTBI). Over time, however, this immunity wanes and the individual becomes susceptible to developing active TB disease either through exogenous re-infection or through endogenous reactivation of LTBI (Bloom, 1994; Flynn & Chan, 2001). Once an individual acquires LTBI, their lifetime risk of reactivation is estimated to be 5-10 percent (Flynn & Chan, 2001; WHO, 2017a).

While most TB infections occur in the lungs, many non-pulmonary anatomic sites can be affected including lymph nodes, pleural space, skeleton, skin, central nervous system, gastrointestinal tract, adrenal glands and others (Bloom, 1994; Friend & Watson, 1998). However, only active pulmonary TB is infectious and it is believed that if left untreated, an infectious individual will transmit TB to approximately 10 to 14 people annually (Styblo, 1984, as cited in Bloom, 1994, p. 52). Without treatment, approximately 50% of people with active TB disease will die within 5 years of diagnosis, 30% will spontaneously ‘self-cure’, and 20% will live with chronic TB disease (Bloom, 1994, p.51). The virulence of TB, as indicated by its high case fatality rate, the ease of transmission with which it travels from person to person, and the difficulties associated with treatment explain why TB poses such a threat to public health.

3 Social Aspects of TB

The biomedical understanding of TB is the current dominant form of knowledge about this disease. While exposure to the pathogen is necessary for the development of disease, it is not sufficient. In majority of cases, with the exception of HIV co-infection, the specific cause of reactivation of LTBI remains unknown (Flynn & Chan, 2001); only a small proportion of all cases can be explained through biomedical factors (Bloom, 1994, p. 50). However, it is highly speculated that the reactivation of LTBI, particularly among immigrant populations, occurs as a result of poor socio-economic conditions (Coussens et al., 2017). This statement points to the limitation of the biomedical understanding of TB and calls for a better explanatory framework, which the social determinants of health (SDOH) perspective offers.
SDOH is an approach that critically examines the root causes of diseases and illnesses beyond their biomedical etiology. The World Health Organization (WHO) Commission on Social Determinants of Health (CSDH) describes this approach in the following way:

The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally, the consequent unfairness in the immediate, visible circumstances of peoples [sic] lives – their access to health care, schools, and education, their conditions of work and leisure, their homes, communities, towns, or cities – and their chances of leading a flourishing life. This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics. Together, the structural determinants and conditions of daily life constitute the social determinants of health and are responsible for a major part of health inequities between and within countries. (CDSH, 2008, p. 1)

This approach considers the role that social and economic conditions play in determining who becomes ill and who remains healthy. The SDOH framework focuses on the extent of power that individuals possess over their physical, social, and personal resources, such as “conditions of childhood, income, availability of food, housing, employment and working conditions, and health and social services,” and the role that these have in achieving their personal aspirations (broadly) and health and wellbeing (specifically) (Raphael, 2004b, p. 1). In short, poor health outcomes are generally associated with poverty because of unequal distribution of power and access to resources. The distribution of diseases such as TB, for example, is therefore inversely proportional to the amount of social, political and economic power that individuals and populations posses.

For decades, TB has been understood as the disease of poverty. Before the advent of chemotherapy for the treatment of TB, McKeown (1976) noted a significant decline in rates of TB, which he attributed to socioeconomic development. Conversely, the unequal distribution of TB mortality and morbidity today highlights the state of socioeconomic deprivation of certain populations, contrasting health inequities between the rich and the poor (i.e. globally, more than 95% of deaths due to TB occur in middle- and low-income nations [WHO, 2017a]). Poor people are more likely to become exposed to and infected with Mtb due to an increased likelihood of living in substandard housing conditions, including crowding and inadequate infrastructure (Farmer, 2001). Although most people do not manifest any symptoms nor ever fall ill, the
chances of reactivation of LTBI increases for those living under conditions of social and economic deprivation; problems such as malnutrition, other concomitant illnesses, as well as addictions and substance abuse all weaken the immune system thus compromising the body’s ability to maintain the TB infection in a dormant state (Farmer, 2001). These physiological conditions are much more prevalent among individuals living in poverty. It is also important to note that health outcomes for impoverished individuals with active TB are much worse in many parts of the world because the poor often have inadequate access to effective therapy. In addition, their socio-economic conditions affect their ability to complete the lengthy treatment regimen without interruption (Farmer, 2001). According to this view, in order to adequately control TB it is necessary to not only consider biological factors, but also incorporate socio-economic and behavioural causes into current TB control strategies (Coussens et al., 2017; Jaramillo, 1999; Lonnroth et al., 2009; Rasanathan et al., 2011; WHO, 2014a,b).

Although the socioeconomic etiology of TB is an established notion in social medicine, Olson and colleagues (2012) challenge the view of TB as a disease of poverty. Their study of TB epidemiology among immigrants in the U.S. shows only a weak association between TB and socio-economic status. While questionable, their research points to some other processes responsible for the high burden of TB among migrant populations in high-income countries, which warrants a closer look.

Health related stigma is an important social process that carries implications for individuals affected by certain health conditions, particularly because of its effects on one’s actions, behaviour and access to power and resources. Stigma can be either experienced overtly or may be only perceived by the sick individual. It is constructed by identifying a characteristic different from the norm – some sort of an undesirable trait (in this case the norm being ‘good health’, and the undesirable trait a disease or adverse health condition), attributing a certain social or moral value to this trait (typically as a result of a claim about the condition which is not supported by medical discourse), and thus devaluing the individual or group of individuals who possess this characteristic or trait (Dodor & Kelly, 2009; Goffman, 1963; Weiss et al., 2006). These social attitudes about one’s devalued self are then internalized by the individual and lead to feelings of shame and guilt (Courtwright & Turner, 2010). Therefore, those with certain health conditions are socially or morally judged based on a feature associated with a disease, ultimately resulting in their exclusion, rejection and discrimination either by themselves, others or both.
Stigma has been recognized as a social determinant of health (Heijnders & van der Meij, 2006), and particularly as a social determinant of TB (Craig et al., 2017) because it is a complex process involving communities, institutions, and social attitudes that results in the production of health inequalities. While the root cause of TB stigma is both the real and exaggerated fear of contagion, other factors, such as its association with poverty, malnutrition, low social status, other infectious diseases such as HIV/AIDS and immoral behaviour, all lead to the loss of status of self and family (Dodor et al., 2008). The implications of stigma for individuals with TB and LTBI are vast. Most notably, stigmatization of infectious diseases causes discrimination and exclusion of those with TB (or those thought to be infected) by their own families, communities and even health care workers (Dodor & Kelly, 2010, 2009), subsequently leading to their physical and social isolation. Therefore the fear of isolation may not only cause delay and/or refusal in seeking or completing treatment (Christodoulou, 2011; Courtwright & Turner, 2010; Cramm et al., 2010; Dodor & Kelly, 2009), but also produce behaviours deemed ‘risky’ by public health (Courtwright & Turner, 2010). Isolation may also leave individuals and their families economically vulnerable by causing disruption in their work, thus leading to financial difficulties (Courtwright & Turner, 2010; Dodor & Kelly, 2009). Being identified as potentially ‘diseased’, whether explicitly or through certain institutional or clinical practices, can perpetuate stigma (Craig et al., 2017). Furthermore, the shame and guilt of being labeled ‘diseased’, and the associated general devaluation by others in society that comes with that label, carries negative consequences for one’s mental health and presents as a more complex health situation than TB alone; the presence of co-occurring TB and mental disorders not only makes it more challenging to treat TB, but more negatively affects one’s overall health and wellbeing (Bender et al., 2012).

The effects of stigma extend beyond the inter- and intra-personal level into the realm of social and health policy, specifically in school, workplace and immigration systems (Dodor & Kelly, 2010; Weiss et al., 2006). The widespread diffusion of stigma into these various social structures reinforces and further propagates TB stigma in society, legitimizing the discriminatory treatment of those perceived to be ‘sick’. While it is not the focus of this study, TB stigma is important to consider as a social determinant of health particularly as it pertains to policy, as well as the role it plays in justifying institutional and social discriminatory practices against immigrants by constructing them as ‘importers of disease’.
4 Global Context of TB

In 1993, the WHO (2014c) declared TB a ‘global public health emergency’. It is estimated that approximately one-third of the world’s population is currently infected with TB. While the death rate has been steadily declining over the past two decades, almost two million people die every year from TB globally (WHO, 2017a). The majority of the global burden of TB is found in only six countries – India, Indonesia, China, Nigeria, Pakistan and South Africa – which alone accounts for two-thirds of the global TB burden (WHO, 2017a).

TB control efforts continue to be undermined by the HIV epidemic, multi-drug resistant strains (MDR-TB), the overburdening of human resources, the decline of public health systems, poverty (defined as the ration of the population living on less than $2 per day [The World Bank, 2011b]), wars and civil unrest, and the increase in global migration (WHO, 2014c). It is noteworthy that while high-income nations acknowledge the need for a global approach to controlling TB, this strategy is not based on a global collective sense of altruism, but is rather viewed as an investment or “a matter of enlightened self-interest” (Bennett et al., 2008, p. 354) since a decline in global TB incidence would translate into a decline in TB among these nations’ immigrants. Many immigrant-receiving nations have seen an increase in reported TB cases during the last decades of the 20th century as they began to receive a greater number of migrants from high TB incidence nations. Fueled by the conceptualization of TB as an ‘imported’ disease from low-income nations where TB is widespread (Weber, 1996), each immigrant-receiving country has developed its own policies and guidelines for the screening, prevention and control of TB among its ‘foreign-born’ population with varying degrees of success (Aldridge et al., 2014; Alvarez et al., 2011; Bothamley et al., 2008; Keal & Davies, 2011; Kehr, 2012; Khan et al., 2015; Posey et al., 2014; Severi et al., 2016). In the following sections I introduce and discuss the strategies adopted and implemented for the control of TB in the Canadian context.

5 TB in Canada

Historically, TB has always existed in marginalized and impoverished communities, or enclaves of poverty. This is just as true for high-income countries as it is for the rest of the world. All over the world, Aboriginal populations have always been disproportionately affected by TB, which is understood as rooted in conditions of socio-economic deprivation stemming from a long history of colonial oppression. Because the rates of active TB declined in the latter half of the 20th
century in North America among wealthier white populations it was believed that TB was ‘eradicated’ in the ‘developed’ world (Ott, 1996). The reality, however, is that TB has never truly left North America; thus, when active cases started to appear again among whites in the 1980s (predominantly as a result of co-infection with HIV), the perception of ‘re-emergence’ or ‘resurgence’ followed (Ott, 1996, p.158).

Immigrants have historically been, and continue to be perceived as ‘importers of disease’, a source of contagion, and a threat to the health of citizens in host countries (Markel & Stern, 2002). The perceived ‘resurgence’ of TB in North America has been further propagated through increased surveillance and detection of TB among immigrants. The majority of new TB cases are concentrated among immigrant populations, or ‘foreign-born’ individuals, which in 2010 reportedly accounted for 67 percent of active TB cases in Canada (PHAC, 2014a). Considering that only about 20 percent of the Canadian population was born outside Canada (Statistics Canada, 2011), the high proportion of active TB cases among this group is exemplary of the health inequities of immigrants living in Canada. While the problem of TB among Aboriginal populations in Canada is significant, consistent with the purpose of this study, the discussion in this section will focus on TB among immigrant populations.

5.1 Immigration & Immigrant Health in Canada

Canada relies on immigration for the growth of its population and labour. As a result, a significant proportion of its population was born overseas. In 2010, Canada accepted over 280,000 newcomers, and these rates of immigration have remained relatively stable since the 1990s (Citizenship and Immigration Canada [CIC], 2011). The classes and respective proportions of people currently entering Canada as permanent residents include family class (22%), economic migrants (69%), and refugees (9%). Additionally, 150,000 and over 90,000 people come to Canada annually as temporary foreign workers and temporary international students, respectively (CIC, 2012a,b).

Before the 1960s, the Canadian government preferred to admit immigrants from European countries. In the late 1960s, the racial and ethnic preferences guiding immigration policies were replaced with a point system, which focused on selection criteria of admission based on professional skills and education (George, 2010). This change resulted in an increase in immigration from low- and middle-income nations and accounts for the multiethnic and
multicultural composition of Canada today. Currently, the majority of permanent residents come from countries in Asia and Pacific, followed by Africa and the Middle East, then South and Central America (CIC, 2013a).

Justified as a strategy aimed at “protect[ing] the health and safety of Canadians, as well as reduc[ing] and prevent[ing] excessive demand on Canada’s health and social services system” (CIC, 2012c), the immigration medical exam (IME) was designed to identify potentially costly chronic health conditions or infectious diseases that are considered to pose a public health risk, including HIV, syphilis, and TB. Screening for TB specifically and the exclusion of individuals with active TB disease from immigrating to Canada dates back to policies developed in 1910 (Dara et al., 2013). These policies have since evolved, particularly after the advent of anti-TB drugs, to the system we have in place today. For individuals applying to immigrate to Canada as permanent residents under the family class or as economic migrants from outside of Canada, the IME must be completed and passed (i.e. HIV-, no active TB infection or any other costly chronic health condition) in the country of origin in order to be granted admission to Canada. Similarly, temporary residents, including visitors, students, and temporary foreign workers must complete and pass the IME if the duration of their stay in Canada exceeds 6 months, if they have lived in any countries where TB is endemic for more than six months consecutively, or if they plan to work in certain occupations (CIC, 2013b). In some cases, refugees may have completed an IME prior to coming to Canada; however, unlike permanent resident applicants, their claims or legal status are not contingent upon ‘passing’ the exam. Because many individuals claim refugee status after coming to Canada, they would be unable to complete this examination in any other country.

It is widely held that reliance on the IME has resulted in the admission of populations healthier than Canadian-born nationals (referred to as the ‘healthy immigrant effect’) (Beiser, 2005). However, the process of migration, such as the resettlement process itself, as well as the circumstances surrounding one’s decision to emigrate, has significant consequences for the health and wellbeing of migrants. Migration is a process of not only social change but also of physical change, as the environment and circumstances of life may vary significantly from those experienced back home. Immigrants are thus more vulnerable and, consequently, bear a disproportionate burden of disease; any health advantage gained as a group through the process of medical selection declines within the first decade after resettlement to levels equal to
(convergence), or even lower (overshoot) than those of native-born Canadians (Beiser, 2005; Newbold & Danforth, 2003). Critics of the healthy immigrant effect have put forth a competing hypothesis, which claims that the evidence for convergence and overshoot are no more than an artifact of an ageing, and thus less healthy, population. Beiser’s (2005) and more recently Norredam et al’s (2014) research, however, gives support and credibility to the healthy immigrant effect with evidence pointing to both convergence and overshoot. Whatever the case, the deteriorating health of Canada’s immigrant population points to serious shortcomings of public policy in securing the health of Canadians.

5.2 Public Health Approaches to TB Prevention & Control

The WHO has outlined three pillars in the strategy towards global elimination of TB: integrated patient-centred care and prevention, bold policies and supportive systems, and intensified research and innovation (WHO, 2014c, 2017a). The most basic components of the first pillar – integrated patient-centred care and prevention – include vaccination, detection and treatment of active TB disease, and detection and treatment of LTBI. While the information provided in this section is specific to the Canadian context (PHAC, 2014a, 2014b), these guidelines are consistent with current recommendations set forth by the WHO.

The Bacille Calmette-Guerin (BCG) vaccine is the only available vaccine in the world that confers protection against TB. While it is typically administered in infancy (within the first year of life) and is included as part of the regular vaccination schedule in 157 countries, the policies and practices surrounding the use of the BCG vaccine vary greatly from country to country (Zwerling et al., 2011). BCG was used in Canada in the first half of the 20th century, but with the declining rates of TB, increased accessibility to anti-TB therapy, as well as uncertainty about the efficacy of the vaccine and duration of protection conferred against Mtb infection, it was eventually discontinued as part of the regular vaccination schedule in Canada (PHAC, 2014a).

In addition to vaccinations, the other plans of action require the timely identification and treatment of active TB cases, and accurate identification and treatment of LTBI among individuals considered to be at ‘high risk’ for reactivation, in order to minimize the transmission and prevent new cases. Currently, given that the majority of cases of active TB in low-burden high-income countries are a result of reactivation of LTBI, the WHO has identified screening and
prophylactic treatment of LTBI as a central focus in the approach to eliminating TB in low-incidence countries (WHO, 2014b). In Canada, the gold standard for active TB testing includes chest radiography, sputum smear microscopy, mycobacterial culture and phenotypic drug susceptibility testing (DST), and nucleic acid amplification tests (NAATs); these test for signs of active pulmonary TB, provide a microbiological diagnosis, and assess TB strains for drug resistance, respectively (PHAC, 2014a, p. 43-45). Current acceptable methods for diagnosing latent TB infection in Canada include interferon-gamma release assay (IGRA) and the tuberculin skin test (TST) (PHAC, 2014a). For the TST, the subcutaneous administration of purified protein from *Mtb* results in a reaction, which occurs 48 to 72 hours after injection and takes the form of an induration at the injection site. A diagnosis of TB infection is made based on the size of the induration, which depends on a multitude of factors (PHAC, 2014a). Individuals with positive results are typically given a chest x-ray to rule out active TB disease, in which case a diagnosis of LTBI is made. Testing for LTBI using TST is thus a two-step process.

IGRA, on the other hand, is a blood test that identifies infection by measuring the amount of interferon-gamma, which are present from exposure to *Mtb*, and released by white blood cells when combined with antigens. The amount of interferon-gamma is measured and compared to a control sample, upon which a diagnosis is made. As with the TST, IGRA cannot distinguish between active and latent infection. However, results can be obtained within 24 hours, and, unlike with TST, BCG vaccination will not cause a false-positive result. Most importantly a follow-up visit is not necessary to obtain the diagnosis (PHAC, 2014a).

Both tests are acceptable for LTBI screening among immigrants (PHAC, 2014a). A positive result of either TST or IGRA does not confirm active disease, but rather indicates exposure to, and infection with, *Mtb*. However, it does require a follow-up medical evaluation involving an assessment of contact history, other underlying illness or conditions, and interview as well as physical examination (including chest x-ray) to determine whether other symptoms of active TB disease are present. If no symptoms are found, the individual is diagnosed with LTBI and a recommendation may be made to begin prophylactic chemotherapy for those individuals considered to be at a high risk for developing active TB (PHAC, 2014a).

The regimen used to treat active TB disease has two phases – intensive phase and continuation phase – which may have different medication schedules. Often, pills are taken daily or thrice per
week for a total of 6 to 9 months in non drug-resistant cases (although, if drug resistance occurs, treatment is more intensive and can last longer) depending on risk factors and response to treatment (PHAC, 2014a). Similarly, the standard treatment of LTBI (chemoprophylaxis) requires taking the drug isoniazid daily for 9 months (or a combination of isoniazid followed by rifampin daily for 6 months and 3-4 months, respectively) (PHAC, 2014a). Preventive treatment, however, is not recommended to everyone and individuals who do not feel that they can complete the whole course of therapy are discouraged from starting (Seemangal, personal communication, March 2012). Treatment goals for both active and latent TB are to eliminate the source of infection (Mtb) and prevent acquired drug resistance; this can only be achieved if chemotherapy is taken according to a strict dosing schedule over a sufficiently long period of time.

The focus of TB therapy management by public health workers and TB health care providers is to ensure adherence to the treatment schedule and completion of the prescribed treatment. The WHO considers Directly Observed Therapy (DOT) as the gold standard of TB treatment and has promoted the strategy since the 1990s (WHO, 2006). DOT is a program where a public health worker dispenses and/or observes the patient swallow each dose of medication. In Canada, it is used for the management of some active TB cases and may be combined with phases of self-administered therapy (SAT) (PHAC, 2014a); DOT is currently not used in Canada to manage cases of LTBI. The underlying logic behind this program is to monitor patients mainly to ensure adherence to the treatment schedule; however, it is also useful to provide support for patients as well as to monitor and manage side effects caused by anti-TB drugs (PHAC, 2014a).

5.3 TB Prevention & Control in the Context of Migration

5.3.1 Medical Screening & Post-Landing Medical Surveillance

The immigration policy in Canada, particularly with regard to the IME, reflects political concern with the protection of the Canadian public from the ‘importation’ of diseases such as TB. Immigration applicants from abroad found to have active TB disease are denied admission to Canada until they complete treatment, while those where LTBI is suspected are granted admission on the condition that they refer to local health services for medical follow-up, and potential treatment, after arrival (Heywood et al., 2003). However, many cases of TB remain undetected; many international visitors, refugee claimants seeking asylum from within Canada,
and undocumented migrants do not undergo an IME prior to entering the country. Furthermore, Canadian residents and nationals traveling to TB-endemic countries are not required to undergo TB screening upon their return. As such, both active and latent TB can potentially unknowingly affect thousands of individuals in Canada.

Canada is one of the few countries with both pre-departure and post-landing immigration screening programs (Alvarez et al., 2011). Referral for TB screening to local public health units in Canada in the context of immigration occurs through two channels: individuals are either referred by Citizenship and Immigration Canada (CIC) for post-arrival IMS based on the results of the pre-departure IME, or as part of the IME among those who initiate the immigration application process from within Canada (Rea, personal communication, March 2012). Approximately 1,500 cases are referred annually to Toronto Public Health for post-landing medical follow-up (Figure 1.1), of which over 95% comply and present to the public health unit. It is important to note that the 5% who do not report to public health officials in Toronto may actually do so in another jurisdiction (Stuart, personal communication, March 2012). Those who are referred by CIC have a condition placed on their landing status; depending on their specific diagnosis and clinical presentation, they are given either 7 or 30 days to report to public health and undergo TB screening. Once they have been ‘cleared’ by the public health unit (the meaning of ‘cleared’ is ambiguous as it does not provide any information regarding the diagnosis or treatment of the individual – it simply means that the individual has made contact with public health officials and reported for their first appointment with an assessing clinician [PHAC, 2014a]) the condition on their immigration application status is removed (Rea, personal communication, March 2012).

The current recommendation for medical surveillance of foreign-born individuals has changed. In the past, immigrants with LTBI who did not initiate preventive treatment had to be placed under surveillance for a period of 2 years (PHAC, 2007). New guidelines state that individuals may be “discharged from follow-up” if they choose not to begin prophylaxis, but they must be informed about the potential risks of reactivation of the latent infection and are advised to return for evaluation if symptoms of active TB appear (PHAC, 2014a, p. 329). While completion of prophylaxis is not considered a necessary condition of landing under the Medical Surveillance
Figure 1.1  Annual LTBI Detection & Treatment Rates Among Immigrants in Toronto, 2010.

* Estimates according to Greenaway et al. (2011).
Source: Toronto Public Health
Program, the guidelines remain vague and unclear with regards to exactly how long immigrants with LTBI who do not undergo prophylactic treatment should remain under medical surveillance.

While the highest proportion of active TB cases are diagnosed within the first two years after initial infection, the reactivation of LTBI occurs in hundreds of individuals even after 5 years since immigration (Walter et al. 2014; Reitmanova & Gustafson, 2012). The Canadian TB post-landing surveillance program is a passive system that targets those individuals who are considered to be ‘high risk’ rather than the general migrant population. Most migrants at risk of developing active TB, and thus those who would benefit most from screening and treatment of LTBI (i.e. temporary workers, exchange students and tourists, as well as permanent residents traveling to home countries for lengthy visits) are missed because there are currently no policies for TB surveillance among these groups. Moreover, Canada does not have an active post-landing screening program for LTBI due to a number of barriers at the patient, provider and institutional levels, including generally low successful treatment completion rates (PHAC, 2014a). Therefore, it can be argued that the current structure of both the screening and surveillance aspect of the TB Prevention and Control program for immigrants in Canada is inadequate as it misses a considerable number of potential cases.

5.3.2 Diagnosis & Treatment

A large proportion of individuals from high-incidence countries (30-50%) (Greenaway et al., 2011) are infected with latent TB. While preventive therapy is not required to fulfill the conditions of landing imposed by CIC, prophylaxis is recommended to many because a significant proportion of active TB cases are expected among those originating from countries where TB is prevalent (Gushulak, 1998). Despite this, however, mass screening for LTBI of all immigrants is not practiced because: 1) it is not considered cost-effective, 2) the Canadian public health infrastructure is insufficient to handle such a huge undertaking, and 3) it would not present a substantial benefit to treat all individuals with LTBI as most are considered to be at low risk of developing active TB (Menzies, 2003).

Currently, the TST is not administered during the standard IME. Referral for post-landing follow-up is made based on the results of individuals’ IME, particularly if any abnormalities were detected on a chest x-ray (Greenaway et al., 2011). The reliance on x-ray imaging for diagnosis of TB without the use of TSTs is very limiting because it does not identify cases of
LTBI or active TB disease where lung tissue is not involved (false negative). Moreover, some health conditions other than TB that cause scarring of lung tissue, or cases where the TB infection has resolved itself but has left scar tissue, may be inaccurately diagnosed as TB (false positives) (Rea, personal communication, March 2012). Additionally, those who have a history of TB are also referred for post-landing surveillance regardless of clinical indicators (Greenaway et al., 2011).

In Canada, individuals who come in contact with public health for TB screening through the immigration process in the context of IMS must undergo a chest x-ray, a physical health assessment, and sputum induction. In addition to these diagnostic tests, individuals’ health history is assessed and they are “questioned for symptoms of active [TB]” (Greenaway et al., 2011, pp. E944-E945) to help make an accurate diagnosis. Individuals with active TB are treated according to the PHAC (2014a) standards described above. The recommendations for initiation of prophylaxis for LTBI are made in cases where the benefits of treatment outweigh the risk of adverse reactions associated with isoniazid use, specifically hepatotoxicity (i.e. decreased liver function), which occurs in up to 5 percent of cases (PHAC, 2014a). Treatment should be avoided altogether or closely monitored in those with heavy alcohol use, pre-existing liver disease, and very old age as these factors increase the likelihood of negative side effects (Greenaway et al., 2011).

5.4 The Immigration Medical Surveillance Process: Obtaining Medical Clearance

The medical examination that takes place in Canada is initiated in cases where an individual undergoing post-landing IMS is suspected of having active pulmonary TB and is referred (either by public health authorities or a general practitioner) to see a TB specialist (see Figure 1.2 for an overview of the pathway from immigration application to TB clinic referral). In the context of immigration, these individuals require proof of medical clearance as part of their condition of landing, which is mandated by CIC. While this process is described in detail in Chapter 5 based on analysis of research data, this section is intended to provide the reader with a brief outline of the IMS process for a ‘typical’ encounter at an outpatient specialist TB clinic in Toronto, Ontario. These descriptions follow the pathway depicted in Figure 1.3, which explain the process involved in completing IMS and obtaining immigration medical clearance.
Figure 1.2  Migrants’ Pathway from Application for Immigration to TB Clinic Referral

Apply for Immigration to Canada from home country / outside of Canada

No TB/LTBI

Immigration Medical Exam (IME) (TB Screening)

LTBI

Referral for Post-Landing TB Medical Surveillance (Flagged by CIC)

Contact local Public Health Unit

Complex case?

Routine case?

TB Specialist / Clinic

Active pulmonary TB

Must complete treatment before entering Canada

GP / Family Physician (TB Screening)

No TB / LTBI

Suspected active TB (pulmonary & extrapulmonary)
* TST, or Tuberculin Skin Test, has already been administered to most individuals prior to their referral to the clinic. In some cases where a TST has not been performed, the TST will be offered during the follow-up visit if considered to be diagnostically beneficial. Source: Batt, personal communication, July 10, 2014).
During the initial visit to the TB clinic, the referred IMS TB patient must first obtain a chest x-ray, as per standard guidelines for clinically diagnosing active pulmonary TB disease (PHAC, 2014a). Radiographic imaging is required for several reasons: there may be no previous chest x-rays provided, or, if provided, they may be either of poor quality, impossible to view (i.e. incompatible software), or they may be several months old (Batt, personal communication, July 10, 2014). It is therefore necessary to repeat a chest x-ray to ensure that there has been no progression or new development of lesions since the last examination in the context of the IME. In some cases, radiographs should be repeated at intervals to allow for comparison and ensure stability (PHAC, 2014a). The individual is interviewed by one of the TB clinic staff about their overall health, migration history, as well as any past history of TB. If the patient requires an interpreter, one may be provided via a specialized telephone service. The clinical interview is followed by a physical exam. Lastly, an induced sputum sample is collected for laboratory testing (mycobacterial culture and smear microscopy). It takes up to 8 weeks to obtain laboratory test results, at which point active TB disease can be either confirmed or ruled out.

The results of these test have one of the following three outcomes: 1) active TB confirmed; 2) active TB ruled out but LTBI suspected (or confirmed, if sufficient information is available); or 3) no active TB or LTBI. Positive mycobacterial culture results, diagnostic of active TB, can be detected as early as 3-5 weeks, at which point the patient is called back to the clinic for a second visit and treatment for active TB initiated as soon as possible (Batt, personal communication, July 2014). Upon successful completion of treatment, CIC is notified and the condition of landing is removed from the individual’s immigration application. If, however, after 8 weeks no positive culture is detected, diagnostically this indicates that the individual is either clear of TB completely or may have latent infection – a distinction made with the help of the chest x-ray, TST, or interferon gamma release assay (IGRA) (a blood test used to determine whether an individual has acquired TB infection) (WHO, 2011a). In either case, CIC is notified that the individual is clear of active pulmonary TB disease, and the administrative process of obtaining immigration medical clearance begins, eventually culminating in lifting the condition of landing for that individual. Those individuals, however, who are diagnosed with LTBI and are perceived by the TB specialists to be at a high risk for progression to active TB disease, are strongly encouraged to begin prophylaxis. The results of one’s diagnosis, as well as any treatment
recommendations and further discussions, are communicated to the patient during the follow-up visit(s) (Batt, personal communication, July 10, 2014).

6 Thesis Overview

In this chapter, I introduced the topic of TB, highlighting both biomedical and social conceptualizations of the disease; I also identified immigrant health as a focus of study. I provided an overview of current approaches to TB prevention and control in Canada among the immigrant population. Lastly, I mapped out some key conversations about the benefits and drawbacks of immigration health screening and surveillance for TB and highlighted several potential knowledge gaps to provide a direction for research on this topic.

There are a total of nine chapters in this thesis. In Chapter 2, I present a scoping review of the extensive biomedical and sociological literature on TB and immigration to situate the present study within three disciplines: public health, medicine, and social health research. I end with the study rationale and research questions guiding this study.

Chapter 3 describes the theoretical framework for this thesis. I present the key concepts relevant to this study, which were developed by Michel Foucault and others who have taken up his work in recent years. I use Foucault’s concept of governmentality as a theoretical framework and describe how discourse analysis serves as both research methodology and method in the present thesis.

In Chapter 4, I describe the methodology and methods used in this study. I provide a detailed description of the research process including participant recruitment, methods of data generation, strategies for data analysis and ethical considerations. I end the chapter with a discussion of study limitations and research quality.

Chapter 5 is the first of three results chapters and answers the first research question. Using participants’ accounts, I reconstruct their migration journeys and combine them into what I call ‘Migratory Pathways’ which depict the steps taken by participants to complete the immigration application and medical screening and surveillance processes, highlighting the barriers and facilitators encountered along the way. The pathways are described using participants’ own accounts.
In Chapter 6, I answer part A of the second research question. I present the discursive strategies and practices used by study participants to negotiate interpersonal encounters with officials, authorities, and experts encountered at different stages during the immigration and settlement process, both pre-departure and post-arrival. Chapter 7 is a continuation of Chapter 6. The results presented in this chapter answer part B of the second research question and present the strategies used by participants to negotiate the clinical encounters with TB specialists in Canada in the context of immigration health screening and surveillance.

In Chapter 8, I discuss the study results collectively, interpreting them through a governmentality framework. The themes and concepts generated through analysis are presented in dialogue with the work of others who have conducted research in the area of TB, immigrant health, as well as those who have used poststructural approaches in health research.

Lastly, Chapter 9 concludes this thesis. I highlight the original contributions of this work to the field of TB and immigration. After a brief discussion of the implications of the study findings for both clinical practice and policy, I provide several recommendations for improving the current approach to TB prevention and control among immigrants in Canada. I describe the limitations of this study as well as future directions, and end the work with concluding remarks, focusing on TB and immigration in a global context.
Chapter 2
Literature Review & Rationale for the Study

1 Introduction

Because TB is a very old disease and affects billions of people worldwide, the body of literature on the subject is extensive. Since both the biomedical and sociological perspectives on TB are important, this literature review reflects the current available research in both areas. The purpose of this literature review was twofold. First, it was undertaken to assess the breadth of the literature and work published on TB, LTBI, and immigration, as well as qualitative studies in the area of TB to more narrowly identify gaps in knowledge and situate the present study. The second purpose was to examine the discourses dominating the literature on the control of TB among immigrants.

I begin this chapter with a description of the search strategy used to map out current empirical research on TB and immigration. I organize the results of this scoping review into seven themes. These themes were selected according to the relevance to the topic of interest in this study. They include: medical health screening for TB and LTBI; decision-making process around preventative treatment for LTBI; treatment access, compliance, and noncompliance; health beliefs and knowledge about TB; immigrants’ experiences of TB screening, diagnosis and treatment; and TB stigma of immigrants. After a critical discussion of the results of this review, I provide the study rationale, drawing attention to current gaps in knowledge on the topic of immigration medical screening and TB surveillance, particularly in the Canadian context. Lastly, I end the chapter with the research questions guiding this study.

2 Search Strategies

I conducted a scoping review of peer-reviewed literature focusing on LTBI treatment and TB control strategies among immigrants worldwide. The databases searched, both biomedical and sociological, include: MEDLINE, EMBASE, PsychINFO, PubMed, CINAHL, Web of Science, IBSS, GEOBASE, Anthropology Plus, FRANCIS, Social Science Abstracts, Sociological Abstracts and Scopus (health sciences and social sciences separately). Additionally, two topic-
specific searches focusing on ‘migration’ and ‘stigma’ were conducted separately using Anthropology Plus, FRANCIS, IBSS, Scopus, Social Science Abstracts, Sociological Abstracts, Web of Science, CINAHL and PsychINFO databases. Search restrictions included peer-reviewed publications in English since January 1, 1996 until June 2014. The search was run by mapping terms to subject heading (MeSH) where available as well as by keyword; otherwise searches were performed by keyword, topic or subject heading, depending on the options available.

Different search terms were used for biomedical and sociological literature, and they also differed somewhat depending on the variations of terms used in each database. Nonetheless, the terms were divided into general categories. For the biomedical literature, these include: disease (TB), population (immigrants) and intervention (TB knowledge) (Table 2.1). Additionally, the results were combined with the term “qualitative” to identify qualitative studies. The search of the sociological literature was divided into four categories: disease specific (TB), disease general (infectious disease), social aspect (TB knowledge) and theory (poststructuralism) (Table 2.2). Lastly, three categories of terms were used to conduct the topic-specific search, which included disease-specific terms (TB), and those related to either migration or stigma (Table 2.3). More specifically, the search results for the disease-specific category were combined with ‘AND’ for both migration and stigma categories separately.

A total of 1396 citations were retrieved (366 biomedical, 283 sociological, 396 migration, 351 stigma) following the first search. When duplicates were removed I was left with 889 citations. I proceeded to review all titles and abstracts, keeping 192 articles that were either definitely or potentially relevant. Upon closer examination I excluded studies of TB that focused on: children/pediatric TB, Aboriginal populations, homeless populations, prison populations, drug-resistant TB, HIV-TB co-infection, TB co-infection with any other diseases or conditions and cost-effectiveness and systems review studies. Because the number of citations remained quite high, I decided to focus my review on studies that looked at TB or LTBI either explicitly or indirectly (i.e. qualitative TB studies addressing knowledge about and attitudes towards TB and/or the disease experience), as well as empirical studies (unless otherwise relevant to the topic of TB and immigration), a strategy recommended by Bloomberg and Volpe (2008). As such, I also made the decision to further exclude epidemiological reports for the following reasons: 1) these statistics are readily available from other sources; 2) these are updated, reported and published
annually unnecessarily contributing to the high number of citations; 3) at this time the Canadian context is most pertinent to this study; and 4) it has already been established that immigrants represent some of the greatest proportions of active cases in most immigrant-receiving countries all over the world. After refining the results, 60 articles were selected for review after the first search was complete.
The original literature search was conducted at the research proposal stage. The original search terms were saved in the databases and were repeated monthly over the duration of the study. Additionally, articles found through Google Scholar, as well as some articles identified in reference lists of relevant studies were added. Since the original literature search was conducted, as the study topic was revised and the research focus narrowed, I was able to identify research articles more relevant to the present study (e.g. qualitative health research with the population of interest, TB research using similar methodologies, research addressing immigration TB health screening and surveillance, research looking at TB among immigrants from high-burden countries of origin residing in low-burden destination countries). In the end, 22 additional articles were identified and included in this literature review.

3 Results of Scoping Review

3.1 Medical Health Screening for TB & LTBI

3.1.1 Immigration TB Screening & Surveillance

Research addressing medical screening for TB primarily focused on the examination of national immigration health screening programs. The specific areas of focus included: screening for LTBI specifically (Pareek et al., 2012); assessing the efficacy of immigration health screening in decreasing the ‘risk’ posed by the ‘importation’ of active TB disease (Aldridge et al., 2014; Aldridge et al., 2016; Asadi et al., 2017; Khan et al., 2015; Severi et al., 2016) or decreasing the risk of reactivation of LTBI (Aldridge et al., 2016); understanding the experiences and other sociocultural effects of immigration TB screening programs and practices on immigrants in destination countries (Horner et al., 2013; Horner, 2016; Nkulu Kalengayi et al., 2016; Seedat et al., 2014); and quantifying the risk of progression to active TB among those screened for LTBI (Blount et al., 2016). Only two of these focused on Canada specifically (Asadi et al., 2017; Khan et al., 2015).

With regard to the efficacy of the national immigration screening programs, some concluded that there were problems with the system(s) examined, arguing that they are not effective or efficient enough (Khan et al., 2015; Severi et al., 2016). In general, however, most studies support the practice of immigration health screening for TB, but called for a stronger focus on screening
immigrants from specific countries with the highest incidence of TB (Aldridge et al., 2014; Khan et al., 2015) as well as a shift towards LTBI screening and treatment (Aldridge et al., 2016; Asadi et al., 2017; Khan et al., 2015; Pareek et al., 2012). Others, however, particularly those undertaking qualitative social health research, determined that mandatory immigration health screening as well as voluntary health screening after arrival in the destination country had substantial negative social and economic effects on those subjected to screening (Horner, 2016; Horner et al., 2013; Nkulu Kalengayi et al., 2016; Seedat et al., 2014). Mostly, the conclusion of these studies pointed to the effects of ‘othering’ due to the underlying focus on biosecuritization of borders against the ‘importation’ of TB rather than the concern with the health of immigrants. These concerns were echoed by others examining policy discourses around the construction of immigrants as a ‘risk’ and a ‘threat’ (Machledt, 2007; Warren, 2013).

3.1.2 Medical Screening for LTBI

Another group of studies examined screening for LTBI specifically. The two main areas of focus among these studies included the acceptability of medical screening for LTBI by immigrants (agreeing to take a TST), and the rates and factors associated with completion of screening for LTBI (presenting for reading of the TST 48 to 72 hours after administration of the test). Testing and completion rates varied. Guh et al. (2011) reported low LTBI testing rates among immigrants in Connecticut. They concluded that rates varied depending on immigration status (documented vs. undocumented vs. visitors) and ethnicity. Three studies reported high acceptance of screening (Brewin et al., 2006; Levesque et al., 2004; Poss, 2000). In a sample of refugees in Montreal the high rate of screening acceptance (76.6%) was attributed to offering LTBI testing during other medical consultations (Levesque et al., 2004). A study of Mexican migrant farmworkers in the U.S. conducted by Poss (2000) revealed that individuals were most likely to accept screening if the opportunity to do so was presented in a culturally appropriate manner, and at a time, place and in a language that would render the program accessible. Brewin and colleagues (2006) conducted interviews with a group of immigrants in London, U.K. and found that screening for TB was not simply acceptable, but was reassuring and considered a privilege by newcomers. It was also viewed as socially responsible by most. Primary care clinics, hospitals, and social services centres were considered acceptable and convenient sites of screening for this population.
While many agree to take a TST, few present to have their results read. Carvalho et al. (2005) reported that only 33% of their participants, who were undocumented migrants in Italy, completed the full TST screening process. Language seemed to be an important factor not only for screening acceptance (Poss, 2000), but also for screening completion, as Carvalho and colleagues concluded that screening adherence was significantly improved if services were offered in the patient’s native language. Conversely, Leng and colleagues’ (2011) examination of screening among Asian and Latino immigrants in the U.S. indicated that acceptance of testing for LTBI was low regardless of language concordance. Lastly, while innovative interventions that tailor screening programs to test individuals at convenient times and locations, such as those made available at people’s place of employment, would improve acceptability and completion of screening (Poss, 2000), it may not necessarily result in a higher acceptance rate of preventive therapy (Gany et al., 2005).

3.2 Decisions Around Prophylaxis

While treatment for active pulmonary TB is mandatory in the immigration context, prophylactic treatment of LTBI is not. As such, for the purpose of this study, it is important to understand under what conditions immigrants decide to undergo preventative treatment. Five articles addressed the likelihood of acceptance of treatment and examined the factors relevant to the patients’ decision-making process. In her study of Mexican migrant workers in the U.S., Wyss, (2003) found that the decision to take up or refuse prophylaxis was made based on a complex interaction of socioeconomic factors as well as beliefs about TB, specifically, and health in general. Guo and colleagues’ (2010) Canadian study of a patient population recruited from a TB clinic in British Columbia revealed that individuals were more likely to accept preventive treatment if the effectiveness of prophylaxis was better, and the course of treatment shorter and with fewer side effects. The screening method for LTBI (TST vs. IGRA) may also affect the decision to accept or reject prophylaxis (O’Donnell et al., 2011). While the stated reasons to explain this include a familiarity, confidence, knowledge and perceived trust in one form of testing over another, these explanations are only speculative.

Lastly, larger structural factors also found to have implications for the uptake of prophylaxis include power relations between patient and provider, as reported by McEwen and Boyle (2007). The researchers found that an unequal power dynamic is likely to result in the rejection of
medical advice. Michaels et al. (2008) interpret refusal of preventive therapy not necessarily as a lack of concern for one’s health, but rather as a discordance of the beliefs and values between patients and health care providers.

What is most interesting about these studies is the ways in which they are discursively framed. With the exception of McEwen and Boyle (2007), the stated objectives of the researchers was to identify factors associated with non-adherence to preventative therapy, rather than looking into the factors that improve adherence for individuals. Given that preventive treatment is optional in the context of immigration health screening, it is surprising that relatively few studies set out to understand patient’s acceptance of treatment and instead focus on refusal.

3.3 Treatment Access, Compliance & Non-Compliance

Again, because treatment for active TB is not optional in the context of migration, the majority of studies included in this section focus on prophylaxis. Prior to the late 1990s, literature addressing compliance with prophylaxis and successful treatment completion of preventive therapy was scarce (Ailinger & Dear, 1998). Over the years, perhaps with growing interest in the treatment of LTBI as a strategy for TB eradication and control in high-income countries, this topic has received wide attention. Treatment completion rates as well as compliance with therapy vary greatly, and are influenced by a myriad of factors, including those related to the organization and management of treatment, the personal and socioeconomic environment, structural factors, and culture or ethnicity.

White et al. (2003) conducted a study of the effects of Directly Observed Preventive Therapy (DOPT) for successful treatment completion in San Francisco and found that individuals on DOPT were much more likely to complete the entire course of prophylaxis compared to those on self-administered therapy (SAT) (70.3% vs. 47.9%, respectively). Similar results were reported by Matteelli and colleagues (2000), who noted lower completion rates for clinic-based supervised prophylaxis, compared to unsupervised treatment regimens among undocumented migrants in Italy. Calder et al. (2001) looked at completion rates for individuals who were on SAT in Auckland, New Zealand. Surprisingly, in their study completion of prophylaxis was very high, ranging between 80.0 and 89.5 per cent, depending on the definition of ‘adherence’ used.
Factors relating to the use of medications themselves were noted to have a significant impact on compliance and treatment completion by some, but not others. Although Ailinger and Dear (1998) did not find that side effects from medication had much of an impact on adherence to preventive therapy for Latino immigrants in the U.S., others argue that higher completion rates for prophylaxis would be more likely if the course of treatment was shorter and had fewer side effects (Ito, 1999), as reported with the use of rifampicin by Haley et al. (2008) and Lardizabal et al (2006). Lastly, Sarivalasis et al. (2013) reported a high rate of completion (80%) of preventive therapy for LTBI among asylum seekers in Switzerland due to a combination of factors, including a short treatment schedule (4 months), the provision of stable housing for newcomers in migrant centres, and close monitoring by nurses, medical staff and social workers throughout the duration of treatment.

Various aspects of the personal and socioeconomic environment were identified as important predictors of adherence to and completion of prophylaxis. Marriage and family / other social support were noted to either predict or improve completion rates of preventive therapy by Hirsch-Moverman et al. (2010) and Ito (1999), respectively. Anibarro and colleagues’ (2010) retrospective observational cohort study revealed a higher than average rate of completion (80.8%) of therapy among immigrants in Spain. An analysis of factors predicting non-compliance found that time since immigration (< 5 years), age, sex, and social factors common among underprivileged populations (such as alcohol and drug use, unemployment and a history of incarceration) was associated with discontinuation of prophylaxis. On the other hand, Ailinger & Dear (1998) found that adherence to therapy was higher among more educated individuals, while demographics such as age and sex had no implication for therapy completion. In addition to socioeconomic, personal and demographic factors, Ito’s (1999) study of Vietnamese migrants in California identified structural barriers such as transportation to and from the clinic, its location, operating hours, wait time and ambiance, and delivery of care in the native language of the patients were affecting compliance. In contrast, Kan et al. (2013) who examined LTBI treatment completion in Sweden found that completion rates were lowest among migrant populations, though the methodology of their study was unable to help understand the factors affecting this outcome.

Ito’s (1999) work highlights the importance of ethnicity and its consideration in provision of care to immigrants. In Calder et al.’s (2001) study, ethnicity, specifically Maori or Pacific Islander
background, was the only factor associated with non-adherence. Furthermore, higher completion rates were observed among foreign-born individuals in comparison to non-foreign born LTBI patients in the U.S., as well as those of Hispanic ethnicity by LoBue and Moser (2003). In a study conducted at a TB clinic in Boston, the researchers found high acceptance (91.2%) but low completion (38.6%) of LTBI treatment among their participants (Parsyan et al., 2007). They concluded that a Haitian or Dominican ethnic background was most highly associated with treatment deferral, and attributed this to potential sociocultural or behavioural factors associated with ethnicity. However, because this was strictly a quantitative study, these interpretations remain speculative.

Three qualitative studies examined the experience of immigrants with accessing health services for diagnosis and treatment of TB. The results of these studies are similar. Forero-Quintana and Grineski (2012) focused on understanding the reasons behind delays to diagnosis for Mexican-born immigrants at the U.S.-Mexico border. Aside from health care provider barriers (e.g. lack of knowledge about the clinical presentation of TB among general practitioners), delays were attributed to economic and social factors, primarily fear of immigration authorities and potential expulsion. Similarly to what Forero-Quintana and Grineski found, in their study looking at experiences of the diagnosis and management of TB from the perspective of Somali immigrants in the U.K., Gerrish et al. (2013) documented significant delays in treatment for active TB due to misdiagnoses. They also noted that their participants experienced significant social and economic hardships during treatment. In contrast, however, their participants reported generally positive experiences with treatment and management of TB, primarily as a result of psychosocial support from both family and health care providers. These findings were similar to Sagbakken et al. (2010) in Norway. Furthermore, while these report on the perspectives of immigrants in seeking treatment, another study in the U.S. examined health care providers’ perspectives about barriers to care among immigrants in New York (Zelnick et al., 2016). The researchers’ findings about the social and economic barriers to seeking care were consistent with others (Forero-Quintana & Grineski, 2012; Gerrish et al., 2013; Sagbakken et al., 2010). In addition, however, they identified the clinic context (private clinic vs. community clinic vs. hospital clinic) as significant, with private clinics presenting the biggest barriers and fewest resources and hospital clinics having fewest barriers and most resources for immigrants seeking treatment for TB. Lastly, and most interestingly, health care providers in this study expressed uncertainty and lack of
knowledge around policies and protocols for screening and treatment of LTBI in this patient population.

The studies presented here highlight the numerous cultural and ethnic groups affected by TB after immigration. It also emphasizes the need for delivering culturally appropriate care and culturally acceptable programs in immigrant-receiving nations. In fact, cultural intervention and management was found to help with not only adherence to and completion of therapy (Ailinger et al., 2010; Goldberg et al., 2004), but also in seeking care for TB overall (Goldberg et al., 2004).

3.4 Health Beliefs & Knowledge About TB

A key aspect in understanding the motivations behind screening, acceptance, adherence to and completion of treatment identified in the literature was that of health beliefs. Numerous studies examined the knowledge, attitudes, and perception about TB among various cultural and minority groups in Western and non-Western contexts (Ailinger & Dear, 1997; Armijos et al., 2008; Ascuntar et al., 2010; Brassard et al., 2008; Caprara et al., 2000; Carey et al., 1997; Colson et al., 2010; Coreil et al., 2004; Gelaw et al., 2001; Gibson et al., 2005; Hasker et al., 2010; Healy, 1997; Hoa et al., 2009; Houston et al., 2002; Humphreys et al., 2017; Joseph et al., 2008; Liefooghe et al., 1997; Long et al., 1999; Martins et al., 2008; Macdonald et al., 2010; Marks et al., 2008; McEwen, 2005; Menegoni, 1996; Michaels et al., 2008; Mushtaq et al., 2011; Navaza et al., 2011; Ottmani et al., 2008; Poss, 1998; Rundi, 2010; San Sebastian & Bothamley, 2000; Steen & Mazonde, 1999; Vukovic & Nagorni-Obradovic, 2011; Wieland et al., 2012; Wyss & Alderman, 2007; Yamada et al., 1999). These studies indicate that individuals hold multiple and often competing explanations of TB based on medical, folk, cultural or popular beliefs. Consequently, these diverse and plural forms of knowledge about the etiology of TB (and LTBI specifically), especially those that are in direct conflict with the biomedical model, may lead to diagnostic delays (Chinouya & Adeyanju, 2017; Zelnick et al., 2016), refusal of treatment or lack of adherence to prophylaxis (Ailinger & Dear, 1997; Ailinger et al., 2004; Colson et al., 2010; Coreil et al., 2004; Gany et al., 2005; Ito, 1999; McEwen, 2005; McEwen & Boyle, 2007; Michaels et al., 2008; San Sebastian & Bothamley, 2000; Shieh, 2006; Wieland et al., 2012). This point is salient particularly in the context of migration because the explanations of TB and LTBI in the health sector may vary in different countries, which may add to the confusion and
challenge of constructing meanings of TB for individuals (McEwen, 2005). It is important to note, however, that knowledge, attitudes, beliefs and behaviours about TB are not associated with or determined by ethnic background, as argued by some (Parsyan et al., 2007), but is rather very much person-specific (Gibson et al., 2005). Also, as Hirsch-Moverman et al. (2010) found, these factors may not always significantly predict adherence to treatment as other factors associated with the social, cultural and economic environment may be more salient.

3.5 The Role of Health Care Workers

With respect to TB care, it is important to consider the role that health professionals, whether that includes physicians (TB specialists, general practitioners, immigration doctors), nurses, clinic staff, or public health workers, play in managing TB in this population. Interestingly, a large portion of the qualitative literature privileged the perspectives of health care workers and professionals over those of immigrants. For instance, some studies found that the attitudes, knowledge and practices of health professionals differ from those of patients (Herselman, 1997) and, through the clinical encounter, directly affect individuals’ perceptions, understanding and experiences of TB, as well as compliance with therapy (Acha et al., 2007; Bender et al., 2011; Dodor & Kelly, 2009; Fochsen et al., 2006; Ho, 2006; Ito, 1999; Menegoni, 1996; Michaels et al., 2008; Sagbakken et al., 2012). The quality of the patient-provider relationship is important not only for the purposes of screening and treatment but also for the overall wellbeing of patients (Bender et al., 2010).

Park and Littleton (2007) note that each “patient, health worker, clinician, public health doctor or public health nurse does TB differently” (p. 6), emphasizing the numerous discourses around TB, and the potential for various interpretations and enactment of policy. Indeed, findings from studies conducted by Breuss et al. (2002), Hirsch-Moverman et al., 2006; Salazar-Schicchi et al. (2004), Savicevic (2009) and Shi et al. (2010) support this claim. Moreover, the discourses around TB, mainly those based on the biomedical model and specifically stemming from the recent approaches to evidence-based medicine, impact the ways in which patients are viewed by health care providers, and thus shape the interaction and power relations in the patient-provider relationship (Lerner, 1997).

Although the decision to accept treatment for LTBI ultimately lies with the patient, the logic of management and control that underpins TB programs indicates that it is laden with diffuse,
dynamic and subtle (or not so subtle) power relations, which ultimately impact an individual’s decision to begin or refuse treatment (Alvarez Gordillo et al., 2000; McEwen & Boyle, 2007; Sagbakken et al., 2012). For instance, Bothamley and colleagues (2008) state that the “public health benefit of the strategy [treatment of LTBI] relies critically on large acceptance and completion rates” (p. 1027); this logic may therefore result in direct or indirect coercion in an attempt to improve the uptake of treatment particularly since the approach to treating LTBI is based on clinician-perceived medical needs rather than those of individuals with TB infection. For this reason it is important to also consider the role that public health officials and health care providers play in governing newcomers not only through direct clinical interactions with immigrant patients, but also throughout the overall migration process.

3.6 Immigrants’ Experience of TB Screening, Diagnosis & Treatment

While the overwhelming majority of scientific health research on TB and immigration is quantitative and framed within the positivist paradigm, qualitative studies that include everyday accounts and experiences of individuals undergoing anti-TB therapy or immigration health screening do exist. The majority of these focus on active TB cases (Chinouya & Adeyanju, 2017; Farmer, 1999; Forero-Quintana & Grineski, 2012; Gerrish et al., 2013; Gibson & Oosthuysen, 2009; Greene, 2004; Harker et al., 2010; Horner, 2016; Joseph et al., 2008; Kelly, 1999; Lewis & Newell, 2009; Macdonald et al., 2010; Nkuluka Kalengayi et al., 2016; Rundi, 2010; Sagbakken et al., 2010; Watkins & Plant, 2004; Zuniga, 2012), leaving a gap in knowledge about the implications of prophylaxis on the day-to-day lives of people with LTBI. Furthermore, while some do utilize qualitative methodologies, critical social studies are more scarce. McEwen’s (2003) critical ethnography, McEwen and Boyle’s (2007) study of power and resistance in the clinical setting, and Horner’s (2016) discourse analysis of policy and immigrants’ experiences of undergoing immigration TB screening and surveillances are only known exceptions. McEwen’s (2003) critical ethnography, McEwen and Boyle’s (2007) study of power and resistance in the clinical setting, and Horner’s (2016) discourse analysis of policy and immigrants’ experiences of undergoing immigration TB screening and surveillances are only known exceptions. McEwen and Boyle’s (2007) paper stems from McEwen’s (2003) doctoral dissertation research, which looks at: the ways in which Mexican immigrants in the U.S. living at the U.S.-Mexico border understand and make sense of LTBI; the ways in which they engage with health providers to negotiate and ultimately resist oppressive TB policies; and the everyday challenges that these individuals and their families undergo in the historical, socioeconomic, political and cultural context. While this research is unique in that it is the only qualitative study of LTBI that
addresses the effects of broader political and social discourses about TB, these are situated within a context of a long political and economic history between the U.S. and Mexico that is geographically and temporally specific. Most importantly, however, in her analysis McEwen (2003) utilizes a limited understanding of power as an oppressive force (as opposed to productive).

Horner (2016) critically examines the experiences of migrants in Australia diagnosed with TB and, along with the perspectives of health care providers, situates this analysis within legal immigration policies and discourses that give rise to the ‘will to knowledge’ around TB, and its implications for the social and lived reality of migrants after arrival in Australia. While Horner uses Discourse Theory as an analytical framework, he does draw on Michel Foucault’s concept of knowledge/power in his work.

Two other studies of TB were found in which power was addressed. Fochsen et al. (2006) interviewed doctors in India involved in providing TB care and found that power differences were prevalent in the patient-provider relationship, with the doctor taking a dominant authoritarian role. However, they also provided empowerment to patients by incorporating a consumerist approach to care, indicating that the power relations can be negotiated and may in fact change throughout the medical encounter. Although the focus of this research was on power, it was interpreted through the lens of gender relations.

The second study conducted by Sagbakken et al. (2012) examined power relations between Somali and Ethiopian immigrants in Norway undergoing treatment for active TB and health care providers in the context of DOT. The researchers discovered that their participants felt as though there was little room to negotiate the structure and organization of care, and that coercion was evidently used. Health providers emphasized the legality of treatment structure and rigidity of policy, which disempowered patients and made them more likely to conform with prescribed treatment. While some accounts of positive experiences of DOT were recorded, the researchers stressed the negative repressive aspects of the patient-provider power relations. Despite their in-depth focus on power relations, Sagbakken and colleagues (2012) did not theoretically interpret their findings.
3.7 TB Stigma of Immigrants

The body of literature on TB stigma and stigma of immigrants is extensive; while both of these areas are well developed, stigma is rarely addressed in the context of both TB and migration. Therefore in this section I attempt to bring these two separate aspects of stigma into one conversation.

The majority of studies that focused on TB and immigrants were quantitative and relied on the use of medical records or regional databases as sources of data; fewer qualitative studies were found. However, one common aspect of TB identified in the literature is that of stigma. Stigma is an important social process to consider because the attitudes and knowledge about TB result in consequences for those either directly or indirectly affected by the disease. Furthermore, various discourses around TB shape these attitudes and, if negative, may result in prejudice against those individuals deemed or perceived to be infected, predominantly due to fear of contagion (Atre et al., 2011; Courtwright & Turner, 2010; Juniarti & Evans, 2011).

In this section I present the results of a secondary literature search, which was conducted to better understand how immigrants’ experience of TB or LTBI screening and treatment in the context of migration has been addressed. Three questions guided this part of the literature review: 1) Does the paper qualitatively address TB stigma of immigrant/migrant populations? 2) Does the paper qualitatively address TB-related stigma or discrimination and its consequences on the migration process? and 3) Does the paper qualitative address the stigma of LTBI and, if so, is it in the context of migration?

Biomedical and public health discourses construct individuals with TB as dangerous and risky to others, while being a newcomer comes with its own set of stigma and discrimination based on a multitude of factors such as race, ethnicity, culture, geography (i.e. area/neighbourhood where one settles), nationality (especially if coming from a TB-endemic country), and immigration status. According to Parmet (2009), this “dangerous-patient perspective interacts with pre-existing prejudices and power imbalances, further stigmatizing and targeting individuals within already vulnerable and marginalized communities” (p. 104). Since TB in Canada predominantly affects newcomers, those immigrants with TB are subject to overlapping prejudice or conflation of discrimination based on both their immigrant status and their TB or LTBI diagnosis.
Through their systematic review of stigma literature in TB, Craig et al. (2007) have identified stigma as an important social determinant of TB. A study by Coreil et al. (2010) serves as an example of the ways in which stigma is shaped by the social and political-economic contexts. Their study is an examination of the discrimination against Haitians in South Florida who are socially marginalized not only due to race (as Black) but also based on their minority status (ethnically Haitian). Furthermore, TB and HIV are prevalent in this population in the U.S. because of a combination of factors including poverty, the high incidence of TB in Haiti, and other structural factors prevalent across society and institutions. As a result, this population is a “victi[m] of double prejudice” in the U.S. (p. 1414); they are both racialized and medicalized and, as a result, are constructed as sources of infection in Florida. Conversely, however, a study conducted by Humphreys et al. (2017) challenges the prevailing notion that stigma is significant for immigrants undergoing screening or treatment for TB. In their study with mostly Asian immigrants in England, participants reported that TB is no longer taboo and, as a result, is not stigmatized in this community. They do, however, acknowledge that this may be attributed to the inaccurate assumption about TB-related risk given that many participants believed that in a low-burden country, TB ceases to be a relevant health concern. These studies collectively highlight that in order to have a solid understanding of the immigrant experience of TB screening and treatment, it is imperative to understand how various social forces, such as stigma, act on constructing different immigrant identities.

Reitmanova and Gustafson (2012) note that the medicalizing discourses of Canadian health policy around TB control are conflated with the racializing discourses of immigrants with TB, as presented in press coverage. In fact, these discourses were found to be mutually constitutive; they circulate throughout society and reinforce the notion that immigrants are a health threat to nonimmigrant Canadians. Lawrence et al., (2008) reported similar results from their analysis of TB representations in New Zealand print media, as did Horner et al. (2013) in their analysis of Australia’s “border control regime”. This constitution of racialized diseased bodies is harmful because it presents a reductionist view of the TB disease process solely based on the biomedical aspects of TB and obscures the complexities surrounding the social, economic and political determinants of TB, which often results in victim blaming. Moreover, these racializing and medicalizing discourses works as a form of ‘othering’ to produce social distance between ‘us’ and the diseased ‘them’ (Chinouya & Adeyanju, 2017; Craig et al., 2017; Horner, 2016; Horner
et al., 2013; Lawrence et al., 2008). The circulation of these discourses completely erase not only personal experience of illness (Reitmanova & Gustafson, 2012) but also decontextualizes TB separating it from the socioeconomic conditions under which TB thrives (Lawrence et al., 2008), thereby constructing and propagating the stigma towards vulnerable individuals and entire migrant communities. Consequently, the ways in which individuals with TB, particularly migrants, are portrayed in the media (and society at large) shapes their social and cultural identity and affects how they experience their illness.

4 Discussion

The results of the scoping review indicate that the majority of research on TB immigration health screening and surveillance, particularly quantitative studies that frame TB within the biomedical model of health and illness, identify some inefficiencies in current systems, but generally support the practice of screening immigration applicants. In these studies, the general conclusion is that immigration health screening presents a benefit to low-incidence immigrant-receiving nations by helping to identify active TB among applicants and protecting against importation of TB from other countries. Furthermore, immigration health screening is also interpreted as beneficial to immigrants themselves as the identification of latent infection is considered to provide newcomers with the opportunity to ‘reduce their risk’ of future disease.

Qualitative studies, particularly those that represent immigrants’ perspectives, challenge some of these conclusions. In these studies, researchers highlight the troubling social and economic implications of policies and practices of immigration health screening and surveillance, most notably the omission of underlying social determinants of TB during the immigration process as well as social, economic, and material conditions of settlement. While some researchers addressed the implication of social and cultural factors associated with migration for preventive treatment, the biomedical and epidemiological literature seem to be relatively silent on the social effects of the intersection between the TB program and the process of immigration; only qualitative studies raise the issue of socio-economic factors as important to this process.

Another consequence of studies considering the efficiency of immigration TB health screening and surveillance is the increasing consensus on expanding immigration screening and treatment to include LTBI. This is not surprising given the emphasis of TB policies on eradication of TB through elimination of the ‘reservoir’ of disease (i.e. by treating LTBI). However, the focus of
studies of LTBI among immigrants is limited. The studies identified through this scoping review indicate that the majority of research in this area centres on compliance with preventive therapy and its successful completion; experiences of immigrants undergoing prophylactic treatment are scarcely represented. A retrospective study conducted by Page and colleagues (2008) highlights the importance of immigrant medical screening on access to LTBI therapy for newcomers to the U.S. They report that individuals who are referred for screening through avenues other than those related to immigration proceedings are less likely to receive prophylaxis. Conversely, however, Levesque et al. (2004) noted that individuals who were offered screening during a consultation for immigration examination were more likely to decline, though this point is not thoroughly discussed. Given that individuals’ perceptions of what is required to obtain medical clearance for the purpose of immigration may vary, it is surprising that the context of immigration is not better documented or explored in qualitative studies concerning LTBI among immigrant populations.

The overwhelming response of positive perceptions about screening in some studies were unexpected and raise the question whether this observation is in any way related to the coercive effects of fulfilling medical requirements to obtain permanent residency or immigration status, or whether the responses given were influenced by the perception of researchers or clinicians as authority figures – a point raised by Levesque and colleagues (2004). Moreover, the results of these studies may have been one-sided because most research participants were individuals who accepted and valued medical intervention and TB treatment, and volunteered to participate in research. By the nature of participant recruitment, it is much more difficult to reach those individuals who refuse treatment for inclusion in studies.

The main goal for understanding lay perceptions of TB in these studies is to improve adherence to anti-TB therapy among individuals. Some researchers emphasize that culturally meaningful patient-centred models of care can increase acceptance and compliance with this therapy in light of varying cultural beliefs and attitudes about TB; others simply call for increased health education either during clinical consultation or through widespread public health messages. While I support the former recommendations and critically question the effectiveness of the latter on the basis of its paternalistic approaches, I argue that these studies are limiting because they fail to address and understand the social and economic implications of these therapies on the daily reality of individuals.
Lastly, while it may appear from this literature review that there are many qualitative social studies on the subject of immigrant TB, this is simply a reflection of my search strategy and inclusion criteria. While I have included almost all qualitative studies on the topic in this chapter, I have excluded hundreds (if not over a thousand) quantitative studies. Qualitative methods have proven both meaningful and successful at exploring and addressing the contextual factors of the management and treatment of TB. However, because the biomedical aspects of TB are the focus of most studies which are conducted quantitatively, Littleton et al. (2008) and Munro et al. (2007) argue that more qualitative and ethnographic research is needed to contextualize these findings and to better understand the daily realities and experiences of individuals with TB, including their pre- and post-arrival conditions, the migration experience itself, as well as structural conditions.

5 Study Rationale

5.1 Current Positions on TB & Immigration

It is widely accepted that TB in Canada exists due to its importation from other countries. As such, immigrants are constructed as ‘importers of disease’ against whom Canadian society must be protected. Molecular studies challenge this notion, indicating that not only is there little or no evidence to support this claim that cross-transmission of TB occurs from ‘foreign-born’ individuals to locals in high-income countries, including Canada (i.e. Barniol et al., 2009; Haase et al., 2007; Langlois-Klassen et al., 2013). In fact, transmission often occurs in reverse – from locals to ‘foreign-born’ (Park & Littleton, 2007). While this viral panic and irrational fear of contagions seems to be unfounded, it does not seem to have had an impact on immigration screening practices in Canada.

There are conflicting opinions about the efficacy and overall benefit of immigration medical health screening for TB. Some support the practice (i.e. Douglas et al., 2017; Falzon et al., 2012; Liang et al., 2015), stating its benefits in preventing and treating active TB cases; others, however, see some benefit, but also highlight the limitations of this practice and, instead of supporting widespread screening for TB of all immigration applicants, advocate for more targeted approaches focusing on individuals form high-burden countries (Khan et al., 2015). In general, however, because only a small proportion of TB cases (both active and latent) are
identified in the context of immigration health screening, it is generally understood that the majority of active TB cases among ‘foreign-born’ populations in immigrant-receiving countries are a result of reactivation of LTBI (Coker, 2004; Cowie et al, 2002; Hyman, 2001; Khan et al., 2015; Pareek et al., 2016; PHAC, 2014b; Ricks et al., 2011; Walter et al., 2014; Zuber et al., 1997).

The WHO (2014a) has officially identified migrants as more vulnerable to developing TB. In fact, Shea et al. (2014) have quantitatively shown that migrants are at a higher risk of LTBI reactivation than non-immigrant populations in the United States, suggesting that either the process of migration itself is in some way a risk factor for TB, or that the post-arrival socio-environmental conditions, such as access to work and a declining standard of living, place immigrants at greater risk of progression to active TB disease. Either, or both scenarios may explain the higher proportion of active TB cases among ‘foreign-born’ populations in Canada (PHAC, 2014a; Beiser, 2005; WHO, 2014a, 2014b). Indeed, as Ott (1996) argues, “[i]t is not being foreign-born that puts a person at risk, but the likelihood of repeated exposure to risk, compounded by poverty and ill health” (p.163). Despite LTBI infection being widespread and common (affecting approximately 2 billion people worldwide [WHO, 2011b]), stigma against it, and individuals with LTBI, persists. While immigrants with active TB disease are perceived as a ‘biological threat’ to society, similarly, individuals with LTBI are discursively constructed as ‘reservoirs of disease’ in biomedical and epidemiological literature (i.e. Houben & Dodd, 2016; Mancuso et al., 2016; Myers et al., 2006; Olson et al., 2012). Constituting these individuals as a ‘threat’ within scientific discourses identifies them as a ‘problem’ and calls for new ‘solutions’.

In response, a focus on LTBI has become increasingly important in contemporary approaches to the control and management of TB. In fact, as incidence rates of active disease decline in immigrant-receiving nations, screening and prophylactic treatment of LTBI among immigrant populations in low-incidence countries with active immigration programs (such as Canada) has become an official global strategy for the eradication of TB by the WHO (2014b). This is reflected in the updated Canadian TB Standards (PHAC, 2014a), which emphasizes the diagnosis and therapy of LTBI among immigrant populations, justifying the practice as “the rational ‘next step’ toward eliminating tuberculosis in Canada” (Campbell et al., 2014, p. 246). But how effective is this approach (from a biomedical perspective) and what are the social dimensions of LTBI screening and treatment?
A recent scoping review looked at cost-effectiveness of screening and treatment for LTBI among immigrants from high-incidence countries. In their analysis, the authors conclude that most studies supported this approach as being cost effective (Zammarchi et al., 2015). This is just one dimension. In terms of efficacy, however, there is evidence of limitations of prophylactic treatment of LTBI. For instance, it is suspected that prophylaxis is ineffective on drug-resistant strains of TB (Hauck et al., 2009). In this case, prophylaxis may not be effective, suitable, or recommended (Centers for Disease Control and Prevention [CDC], 2016). Furthermore, while some argue that only a minority of individuals with LTBI will ever progress to active TB disease, and that the risks associated with LTBI treatment may outweigh the potential benefit of this preventive approach (Smith & Menzies, 2011), others contend that preventive TB therapy is safe (LoBue & Moser, 2003) and that it is a useful and appropriate strategy to prevent a significant number of active TB cases (Bothamley et al., 2008), particularly among immigrants (Greenaway et al., 2011; Gushulak, 1998; Kehr, 2012; Khan et al., 2015). Despite it’s potential benefits, however, Cain and colleagues (2008) recommend that prophylaxis should not be initiated unless adequate monitoring can be provided. Zumla et al. (2011) critically question: 1) the reliance on prophylaxis, stating that not enough is understood about LTBI; 2) the interaction of Mtb with the human immune system; and 3) the way in which isoniazid interacts with and eliminates latent Mtb.

Sterling et al. (2006) cited that a significant number of individuals in Canada and the United States initiate preventive TB therapy. However, because the current recommended treatment regimen is lengthy and the medication used is known to have toxic side effects, this typically leads to unsatisfactory completion rates, ranging from as low as 11% up to 53% (Bothamley et al., 2008; Lardizabal et al., 2006; Parsyan et al., 2007; Smith & Menzies, 2011; Trauer & Krause, 2011). According to Kan et al., (2013), in comparison to local populations, immigrants were found to be less likely to complete preventative treatment. On the other hand, some treatment programs have been successful, with completion rates as high as 80% (Sarivalasis et al., 2013); according to the researchers, this success is attributed to integrated patient-centred care and a focus on addressing the underlying social determinants of TB (e.g. providing stable housing). These results imply that to be effective, typical biomedical approaches to treating patients with LTBI need to address underlying social conditions of individuals’ lives.
Fortunately, the importance of SDOH has been acknowledged federally in Canada. The Public Health Agency of Canada (PHAC) stated that for newcomers, “[s]ocial determinants of health, such as poverty and the stresses associated with integration into Canadian society, may increase the risk of latent TB infection acquisition or progression to active TB disease” (PHAC, 2014b, p. 4). While the inclusion of SDOH in the Federal Framework for Action is a positive step towards developing a more inclusive and holistic approach to TB prevention and control, unfortunately there has been limited incorporation of this perspective into the clinical and public health guidelines. As it currently stands, while underlying social factors are mentioned as important determinant of TB among immigrants in Canada, specific guidelines and strategies that actually adopt SDOH are directed at Canadian Aboriginal populations (PHAC, 2014a; Reitmanova & Gustafson, 2012). As a result, only biomedical risk factors such as medical conditions (diabetes, HIV, transplantation, carcinoma etc.) and demographic factors (i.e. age, place of birth and immigration class [refugees]) (PHAC, 2014a) are recognized by PHAC as contributing to the reactivation of LTBI among immigrants.

5.2 TB & Immigration: Research Directions

In line with the current evidence, several knowledge gaps can be identified indicating several directions for research in this area. First and foremost, it is clear that TB is both “biologically and socially complex” (Farmer, 1997, p. 356, emphasis added). As such, it requires not only biomedical responses to solve it, but also social ones. With the rise of drug-resistance TB worldwide, an effective response is needed now more than ever. Farmer (1997) calls for social scientists to conduct inquiries into the social mechanisms responsible for the continued development and proliferation of TB, with the aim to propose novel social responses.

Second, conflicting positions on whether TB immigration health screening and surveillance is beneficial warrants further examination. While some argue that the current health screening and surveillance system for TB in Canada is successful (Elwood, 2009; Langlois-Klassen et al., 2013), others have challenged this assertion (Khan et al., 2015). Furthermore, some have taken a critical approach to problematize immigration health screening. Wickramage and Mosca (2014) argue that while immigration applicants are required to undergo a health assessment to determine their eligibility, the system “often operate[s] within a ‘vacuum’, with little or no formal linkage to the public health system of the country of origin” (p. 9958). This implies that while
immigration screening may identify potential health conditions through medical diagnosis, there is no guarantee that the individual will be able to access the appropriate medical care after arrival in the host country. According to some, (Falzon et al., 2012; WHO, 2014a), this is a legitimate concern. Immigrants “often face several barriers to care in a new country as a result of inadequate knowledge of, or coverage by, the health care services, differences in culture and language, lack of money, comorbidity, concern and discrimination and fear of expulsion” (Falzon et al., 2012, p. e7524-1; also Forero-Quintana & Grineski, 2012); they are also more vulnerable to TB given that their access to medical care may be dependent on contracts, work permits, or insurance coverage (WHO, 2014a, p.1).

Post-landing follow-up medical surveillance for TB is designed to not only detect active TB disease among applicants, but also to identify and potentially treat LTBI among newcomers (Elwood, 2009); currently, however, it is unknown whether this is successful (Khan et al., 2015), nor is it understood how the process of medical surveillance impacts newcomers to Canada. As Degeling et al. (2017) suggest, there is potential for this practice to have negative effects on immigrants. The authors question the ethical dimensions of targeting ‘high-risk’ groups in low-incidence nations (which includes immigrants) for screening and preventative treatment of LTBI on the grounds that such an approach carries the potential for further marginalization of already vulnerable populations.

Against this backdrop, it becomes apparent that biomedical strategies and potential solutions to TB prevention and control dominate the field of TB. Immigrants are more vulnerable to developing TB after migrating to a new country. Despite SDOH being acknowledged, policy statements and guidelines indicate that they are not incorporated into the immigration screening and surveillance program in Canada. In spite of arguments in favour of immigration TB screening and surveillance, it is still not clear who really benefits from this practice. Given the underlying concern with identifying ‘risky’ immigrants and labeling them as a ‘threat’, it appears that the immigration health screening and medical surveillance program in Canada prioritizes the health of the broader local population rather than concerning itself with ensuring the health and wellbeing of newcomers (particularly those at highest risk of developing active TB). Since most cases of active TB disease are a result of reactivation of LTBI, however, it becomes important to better understand the post-arrival conditions of immigrants with latent infection and the
circumstances of the current immigration TB Prevention and Control program during the early settlement period, as pointed out by Khan et al. (2015).

Others have pointed out that the dominance of biomedical approaches leave a knowledge gap around how the process of immigration health screening and surveillance for TB impacts the day-to-day lives of newcomers. Abarca Tomas et al. (2013) call for incorporating immigrants’ perspectives to better understand their experiences with TB during migration (both pre-departure and post-arrival), particularly within the “social, economic and legislative context in which they live at [sic] host countries” (p. 1). This is echoed by Lin and Melendez-Torres (2016), who argue that more studies are needed to examine the nuanced relationship between immigration (particularly immigration status) and adherence to TB treatment regimens from a SDOH perspective. Social research that privileges the perspectives and experiences of newcomers would help to reveal not only the mechanism by which the TB immigration health screening and surveillance process functions, but also its implications for immigrant populations. As mentioned earlier, with few exceptions (Gibson et al., 2005; Horner, 2016; Horner et al., 2013; McEwen, 2003; McEwen & Boyle, 2007), critical research in general (and poststructuralist theory) is largely absent from research about TB in the context of migration. I therefore propose to use poststructuralist theory to interpret immigrants’ experiences with immigration health screening and medical surveillance for TB.

While some have utilized Foucault’s theories of power (Foucault, 1995, 1978) to study various aspects of public health (Lupton, 1995, 1997, 1999; Nettleton, 1997; Ong, 1995; Petersen, 1997; Lupton, 1997) and Petersen (1997) bring attention to an area of study that has not been sufficiently addressed by Foucauldian scholars; that is, the ways in which individuals react to medical and public health discourses and strategies, and the implications this has on the daily reality of individuals. It is therefore my goal to examine how power is negotiated at the level of everyday life for individuals undergoing immigration health screening, and how these individuals respond to various strategies and techniques of power (i.e. how are they negotiated, taken up and resisted) at various stages of the immigration and settlement process. This perspective brings into question the roles that individuals undergoing immigration TB screening and surveillance play in their own management of health, specifically, and life, generally. Furthermore, this theoretical approach would also interrogate current immigration policies and practices around medical health screening to examine how they operate as tools for regulating
individuals and populations, and determine whether these policies function the way in which they were intended (Shore & Wright, 1997).

6 Research Questions

The overarching question guiding this research asks:

How do newcomers experience the process of surveillance for a highly stigmatized disease, such as tuberculosis, during their immigration and settlement process, and what effects does this process have on them as new Canadians?

Based on this question, two secondary questions arise:

1. How are immigrants governed through intersecting Canadian policies on immigration and public health during the immigration and settlement process, both in-Canada and abroad?

2. How do immigrants undergoing TB surveillance negotiate power throughout the different stages of the immigration and settlement process?
   - Part A: In international and national settings (pre- and post-migration)
   - Part B: During the Canadian TB clinic encounters
Chapter 3
Theoretical Framework

1 Introduction

In this chapter, I describe the theoretical framework used to situate immigrants’ experiences of undergoing immigration health screening and TB immigration medical surveillance (IMS) as part of the immigration and settlement process in Canada. I begin this chapter by introducing the ontology and epistemology of poststructural theory. The remainder of the chapter is separated into five sections. In the first section, I introduce poststructural theory and outline its key ontological and epistemological tenets. In the second section, I define governmentality, explaining how it is used as a conceptual framework. In the third section I write about power, describing the different forms of power, how they operate, and some of their effects; I also include a section that describes the various strategies and forms of resistance that are possible. In the fourth section, I write about the importance of public health and medicine to Foucault’s theories, highlighting the connection between public health and governmentality. Finally, I end the chapter by discussing how Foucault’s concepts will be applied to the present study.

2 Poststructuralism: Ontology & Epistemology

This study is framed from a poststructural perspective, a theory that is situated within the critical social paradigm. A poststructuralist approach is typically adopted in research to address questions that interrogate the relationship between the individual/self and the social (Wright, 2003). Research within this tradition is distinguished by rejecting value-free forms of scientific inquiry and is mainly concerned with questions that focus on issues of power, justice and social change (Green & Thorogood, 2009, pp. 18-19). Theoretical work within this paradigm is guided by the ontological assumptions that ‘truth’ and ‘reality’ are not objective and extrinsic, but rather intrinsic where multiple competing versions exist at any one point in time (Gastaldo, 2006; Prasad, 2005; Smart, 2002). Furthermore, ‘truth’ or ‘reality’ is shaped by a multitude of power relations that operate throughout society, and are constructed by the various ways in which individuals talk, think and write. And on the subject of the self, a poststructuralist ontology assumes that just as there is no one ultimate truth, there is no one ‘true’ self; instead, each
individual has multiple versions of the self (Gastaldo, 2006; Prasad, 2005; Smart, 2002; Ransome, 2010). Epistemologically, ‘truth’ is understood as the dominant form of discourse in society and is intrinsically tied to knowledge, which is nothing more than a sociohistorically-bound construct of the current dominant discourses.

The theoretical and analytical foundations for the present study are based upon Foucault’s work on the construction of power as well as some of his other concepts. Primarily, Foucault’s concept of ‘governmentality’ will provide a framework that allows for an examination of the ways in which power operates to govern the day-to-day lives of immigrants undergoing immigration health screening and surveillance for TB as part of the immigration and settlement process. Other concepts such as bio-power, technologies of domination and technologies of the self feature prominently in this conceptual framework and are unpacked in the following sections in relevance to the context of this study.

3 Governmentality

Governmentality is essential to my analysis of immigration and TB medical surveillance. In its most basic sense, power becomes “a question of government” (Foucault, 1982, p. 221). Foucault took up the notion of ‘government’ as an activity or a practice (Gordon, 1991, p. 3), which specifically refers to the exercise of power to govern both the self and others. This term itself may be understood in two ways. First, in order to examine the technologies of power in a given society, one must consider the political rationality upon which society functions (Lemke, 2000). This refers to the ways of knowing and understanding how the activity of government is achieved and maintained as well as its nature, i.e. who and what can be governed, and by whom (Gordon, 1991, p. 3). Therefore, ‘government’ is conceived here in a political sense, as intricately tied to the aims and objectives of the state.

The second meaning of ‘government’ has to do with the forms or technologies of power that constitute the subject, or, in Foucault’s words as “the conduct of conduct” (Foucault cited in Gordon, 1991, p. 48), or, very broadly, as the “techniques and procedures for directing human behavior” (Foucault, 1997a, p. 81). Governmentality, as defined by Foucault, is

The ensemble formed by the institutions, procedures, analyses, and reflections, the calculations and tactics that allow the exercise of this very specific albeit complex form of power, which has as its target population, as its principal form of knowledge political
Thus ‘governmentality’ is seen as a technology of government used not only by the state, but is also one that extends into the daily existence of individuals and, indeed, into their very selves, providing guidance on how to manage oneself in life (one’s family, body and soul) (Holmes & Gastaldo, 2002); this form of self-regulation requires agency and liberty (the freedom of choice), and is achieved not through domination, but rather achieved through the alignment of personal desires, needs, and aspirations of individuals and populations with the ends of government (Rose & Miller, 1992). As such, freedom, agency, and subjectivity are central to government and order of society (Rose & Miller, 1992, p. 189).

In recent years, governmentality has been taken up and developed as a conceptual framework for pursuing questions concerning both the limits of government, or its dispersal into all aspects of social life, as well as the questions of how this can be accomplished and how it is operationalized (O’Malley, 1998/1999). Analytically, the strength of ‘governmentality’ as a conceptual framework lies in its ability to simultaneously explain control at the level of the individual and at the level of population (Gordon, 1991). As governmentality occurs through the intersection of three forms of power: sovereign power, disciplinary power, and the government of the self and others (Holmer Nadesan, 2008; Holmes & Gastaldo, 2002), it becomes essential to not only understand these forms of power, but also the forms of resistance that are made possible.

4 Power

Michel Foucault’s work has been significant to the development of poststructural theory. It was driven by his desire to understand not only the relationships of power, but also the nature of their intersection with social institutions and individual practices (Prasad, 2005). The specific questions guiding Foucault’s work were: “how is [power] exercised; by what means?” and “what are the effects of the exercise of power?” (Foucault, 1978, pp. 94-97; Smart, 2002, p. 77). Foucault’s concept of power, in terms of both its nature and the form it takes, differs from the traditional structuralist understanding of power as an oppressive force possessed by a dominant social group and exercised for the exploitation of other ‘powerless’ groups. To Foucault, this explanation was limiting because it only allowed for an economic analysis of power. A non-economic conceptualization of power developed by Foucault allows for power to be
conceptualized not only in negative and hierarchical terms, as repressive and punitive (Foucault, 1995), but also as productive and enabling, having positive effects on individuals and populations (Foucault, 1978, p. 137).

A second point of contention for Foucault regarding power is the form that it takes. Power is not tangible; it is not something that can be possessed by any group or individual. Instead, power is a form of social relations that exist as a complex capillary network or a grid that permeates all aspects of social life; it is exercised. As he writes:

Power is employed and exercised through a net-like organization. And not only do individuals circulate between its threads; they are always in the position of simultaneously undergoing and exercising this power. They are not only its inert or consenting target; they are always also the elements of its articulation. In other words, individuals are the vehicles of power, not its points of application. (Foucault, 1980, p. 98)

Because it is not central, power is exercised from various points, not only from the top down but also from the bottom up, enmeshing every single individual at every level of society and constituting them as both subjects and objects of knowledge. This form of power results in multiple points of resistance exercised by any number of individuals at various locations and levels along this network, or grid (Foucault, 1978, pp. 94-95). Thus the work of Foucault shifts the understanding of power away from its conventional use as reference to state control and toward a new conceptualization of power as a form of social control at the level of the individual.

As with power, Foucault challenges the conventional conceptualization of ‘knowledge’. To Foucault, knowledge, particularly scientific knowledge, is not something produced by individuals, but is rather produced anonymously (Mills, 2004). His objective was to understand the “mechanisms by which knowledge comes into being and is produced” (Mills, 2004, p. 68). Foucault contended that knowledge and power are intricately intertwined: “The exercise of power perpetually creates knowledge and, conversely, knowledge constantly induces effects of power” (Foucault, 1980, p. 52). Knowledge is therefore the conjunction of power relations (i.e. knowledge/power) (Mills, 2004). Knowledge is produced wherever there is an institutional imbalance of power; those institutions / states / groups of people that are able to exercise power in relation to others are the ones that produce knowledge about those who cannot access this power (Mills, 2004). In this way, the production of knowledge about an individual (other or self)
turns them into “an object of discourse, an object of power/knowledge” (Mills, 2004, p. 73).

Power, therefore, as a productive force forms knowledge, and produces ‘truth’ and discourse (Foucault, 1980, p. 119).

4.1 From Sovereign Power to Biopower

The deployment of power is directly connected to bodies and how they function (Foucault, 1978, pp. 151-152). Historically, however, there has been a transformation in the ways in which power was exercised. The pre-modern form of power was one deployed by the sovereign, endowing him with “the right to take life or let live” (Foucault, 1978, p. 136, emphasis in original). This absolute form of power, sovereign power, was deductive, where “things, time, bodies, and ultimately life itself” (Foucault, 1978, p. 136) were subject to seizure by the sovereign. Starting in the 18th century, the form of power changed from a sovereign deductive power to one that fosters life. This biopower is “power that exerts a positive influence on life, that endeavors to administer, optimize, and multiply it” (Foucault, 1978, p. 137).

Sovereign power still exists and operates in contemporary society. The modern expressions of sovereignty are visible through political authority of nation states in law and rule (Holmer Nadesan, 2008; Lilja & Vinthagen, 2014). It is the enforcement of juridical rule to punish, repress, or exclude ‘deviants’ through disciplinary techniques and institutions. It is forceful, totalizing constraint, and is present in certain practices of government, such as “national sovereignty over territory unified by practices such as language or law” as well as military force and warfare (Rose & Miller, 1992, p. 178). As it relates to the present study, sovereign power is useful to conceptualize the geopolitical border (i.e. the international borders of nation states) as a ‘sovereign border’ (Warren, 2013). Thus sovereign power of nations is exercised to ensure its security, and relies on institutions and techniques of discipline to monitor movement across the border and enforce sovereign power to ensure its protection. The emergence of biopower thus opened up the possibility for novel forms of social regulation, which operated at the level of the individual as well as the population. For the first time in history, biological existence became intertwined with political power.

Within a nation’s borders, however, biopower is the most salient form of power used to control and regulate individuals and populations; it is the most important form of power in contemporary
societies. Rather than being punitive and forbidding (and thus inducing fear), as sovereign power is, biopower is enabling; it is interested in steering the general behaviour, stimulating the tendencies and governing of how life is reproduced, and how productive society is. It is a power that is trying to improve the quality of life of its members, their cooperative ability as well as other qualities of the population. (Lilja & Vinthagen, 2014, p. 118)

Biopower is focused on the production of discourses and practices that operate to organize and manage the conduct of individuals and populations. Through the production of knowledges and discourses, biopower is central to shaping perceptions and constructing subjectivity, which it does in subtle ways (Reynolds Whyte, 2009). Subjectivity is the construction of the self. The self, according to Foucault, “is not a substance. It is a form, and this form is not primarily or always identical to itself” (1997c, p. 290). In contemporary society, individuals are categorized and conduct themselves (or not) in ways that conform with dominant discourses (Reynolds Whyte, 2009). The subject (identity) thus constitutes itself in a specific form (i.e. as a ‘healthy’ subject, ‘sick’ subject, ‘risky’, etc.) through institutional practices and practices of power (Foucault, 1997c). Because of this relationship between power and the self, subjectivity is intrinsically “linked to established forms of knowledge” (Holmes & Gastaldo, 2002, p. 559) and ‘truth’.

Lastly, as the example of subjectivity production shows, biopower operates from ‘within’ rather than from ‘without’ as it informs practices and behaviours, shaping subjectivities through self-regulation (Holmes & Gastaldo, 2002).

4.2 Anatomo-politics & Biopolitics

As Holmer Nadesan (2008) writes, “[b]iopower, as the synthesis of biopolitics and anatomo-politics, stands as the most pervasive expression of power in the modern period.” (p. 211). The first of the two poles of bio-power, anatomo-politics of the human body, operates at the level of the individual. Under anatomo-politics, the body is conceptualized as a machine, one that must be effectively disciplined, optimized and maintained in order to become simultaneously economically useful and politically docile (Foucault, 1978, p. 139; Smart, 2002, p. 93). Disciplinary power works through techniques of normalization by constituting the individual as an object of knowledge. “Normalization in the disciplinary sense thus implies ‘correction’ of the individual, and the development of a casual knowledge of deviance and normalization”
The strategy used to reach every individual and gain knowledge about “the smallest twitches of [their] body and the most minute stirrings of [their] soul” was that of confession – speaking about one’s most intimate feelings and thoughts – which transpired in social interactions such as medical examination, education, interpersonal relationships, and essentially every aspect of daily life (Dreyfus & Rabinow, 1982, pp. 169, 174).

The form of biopower associated with regulatory controls at the population level is known as biopolitics. According to this view, the body is understood in terms of its function as part of a collective whole. Biopolitics is exercised over life through the collection of information on, and the supervision and regulation of, the species body, and the characteristics of biological processes such as mortality, fertility and births, health, life expectancy as well as the factors that cause these to change (Foucault, 1978, p. 139). Biopower is a ‘technology of power’ that is concerned with the task of organizing individual subjects as a population for the purposes of governing by ‘taking charge of life’ (Foucault, 1978; Lilja & Vinthagen, 2014, p. 109-110).

In contemporary society, biopolitics does not operate through disciplinary mechanisms, but rather through security mechanisms (Holmer Nadesan, 2008), particularly ‘risk politics’ (Rose, 2001). As such, contemporary biopolitics is linked with both human sciences in general, and clinical medicine in particular (Rose, 2001). The ‘truth regimes’ or life sciences, or the knowledges produced within these discursive fields, define both the ‘normal’ and the ‘deviant’ in biomedical terms (Rose, 2001), typically as juxtaposition between ‘healthy’ and ‘pathologized’. Therefore, for biopolitics to be effective (that is, to successfully persuade subjects to act and think in ways that promote their health, wellbeing and, ultimately, their social utility), individuals had to be first made visible through new forms of surveillance (Lupton, 1997, p. 99). As such, demography and statistics arose as governing techniques used to control and regulate populations.

4.3 Disciplinary Power & Technologies of Domination

According to Foucault, the emergence of biopower allowed for the expansion of these new technologies of power situating the body, the population and all the processes of life itself under constant scrutiny and control (Foucault, 1978). It is thus evident in Foucault’s work that ‘governmentality’ as a technology of government inextricably links the constitution of the subject to the formation of the state, as the emergence of one was dependent on the other.
In this section I briefly describe the function of technologies of domination and explain the ways in which it operates to discipline and control bodies.

Domination is achieved through disciplinary power, which is exercised at the level of the individual and always targets bodies. The goal of disciplining the body is to simultaneously render it more obedient and useful, or in other words to achieve a “docility-utility” (Foucault, 1995, pp. 137-138). Discipline became a “policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour” (Foucault, 1995, p. 138). In order to become disciplined, it is necessary to obtain great and minute detail about the individual and the body through various techniques, methods and knowledge in order to determine how best to control it and attain maximum utility. Discipline functions in several ways: through the organization of individuals in space for their control and observation; through ranking, classification and distribution of individuals not only in physical locations, but also in relation to one another; and through the regulation of bodies as they are conditioned, trained and indoctrinated with certain knowledge or truths through the modification of behaviours and attitudes. In these ways bodies are coerced to fit with the aims and objectives of this form of power.

Three instruments are central to the success of disciplinary power: hierarchical observation, normalizing judgment, and the examination (Foucault, 1995, p. 170). Observation is necessary because in order to place an individual under surveillance for the purpose of control, they must first be made visible. The points of focus are the activities, which through the very act of being seen, are judged, thus making offenses less likely. Those under surveillance are aware of being watched and consequently adjust their actions and behaviours accordingly. Therefore the ‘disciplinary gaze’ is an apparatus comprised of a network of elements through which power is produced as it acts on the bodies of those being watched.

Normalizing judgment acts to correct those bodies that deviate in some way or another from the norm. This is achieved in two ways. First, non-conformity is subject to punishment, and second, correct behaviour is encouraged with rewards. Punishment typically takes the form of classification, ranking or labeling, as well as exercise and intensified training (Foucault, 1995, pp. 179-180). Rewards, on the other hand, can take the form of privilege or awards. These punishments and rewards ultimately hierarchize and judge not actions but individuals themselves
in terms of their value in relation to each other (Foucault, 1995, p. 181). Individuals are therefore incited to correct their behaviours and practices in ways that are acceptable through the desire to be rewarded (which reflects the productive aspects of disciplinary power) more so than out of fear of punishment (or the dominating/repressive aspects of disciplinary power) (Foucault, 1995, p. 180). This form of disciplinary power requires an authority figure to assess acts, to judge when an offense has taken place, and to administer both the punishment and the reward.

The third instrument of disciplinary power, the examination, is a combination of the previous two instruments. The examination is conceived of as a normalizing gaze, one that simultaneously observes, classifies and punishes (Foucault, 1995, p. 184). It “manifests the subjection of those who are perceived as objects and the objectification of those who are subjected” (Foucault, 1995, pp. 184-185). By rendering the individual visible, knowledge about them is gathered and power is exercised over them. The examination thus becomes a “space of domination” by objectifying individuals and making them visible, and through visibility the examination becomes transformed into the exercise of power (Foucault, 1995, p. 187). The second point Foucault makes is that the knowledge gathered through the examination is captured in documents. This documentation led to the third effect of the examination – individualization – by making each person a distinct ‘case’. The descriptions and knowledge about each case are unique, which allows for measurement, judgment and ranking of the individual themselves. This, Foucault writes, is the “means of control and a method of domination” (1995, p. 191).

4.3.1 Technologies of the Self

While disciplinary power functions to obtain a certain level of domination or control over an individual, practices of the self require active participation by an individual on themselves through the internalization of disciplinary power. In other words, technologies of domination constitute individuals as subjects; conversely, individuals constitute themselves as subjects through technologies of the self (Taylor, 2011). This type of technology allows individuals to engage in certain practices or perform modification to one’s own body, soul, attitudes and behaviours in order to achieve a certain state of happiness, morality, or perfection (Foucault, 1988, p. 18). Just as knowledge of others is required to exercise disciplinary power, it is also necessary to know the truth about oneself from within, to discover and disclose (i.e. self-examination) it in order to exercise power over the self, or to govern oneself.
Self-care also involves taking up certain techniques, tactics and strategies in order to engage in the never-ending task of constant reflection, self-improvement and self-(re)constitution; it is the prerogative of the modern enterprising individual, the one that has been constructed in neo-liberal democracies – a subjective, autonomous, and responsible being who strives for fulfillment by thinking, judging and acting on the self and one’s life (Rose & Miller, 1992). The autonomous self is thus inextricably linked to contemporary forms of governmentality because the enterprise of the self, all the ways in which individuals should conduct themselves, is in line with political rhetoric (Rose, 1990; Rose & Miller, 1992). The success of government thus depends on the autonomy and freedom of individuals.

Technologies of the self are central to the current therapeutic culture. Self-government is the alliance between individuals who want to improve their quality of life and the experts who claim to have the objective knowledge of how to conduct one’s life in order to achieve this goal (Rose, 1990). This concept has greatly contributed to the understanding of public health and preventive medicine particularly in Western societies based on the premise that rehabilitation, or treatment, requires active participation on the part of the modern subject and calls for the adoption of technologies of the self in accordance with biomedical discourse. The strategies of public health are directed at the management and control of populations in order to minimize all potential health risks not through the alteration of environmental conditions, as in the past, but through targeting individuals and encouraging them to engage in self-directed forms of control (Lupton, 1999, pp. 96-97).

4.4 Power & Resistance

As explained above, all three forms of power (sovereign, disciplinary, and biopower) operate in contemporary Western societies. In essence, it can be argued that contemporary power is a ‘dyad’ or both productive, as well as repressive forms of power (Lilja & Vinthage, 2014). As such, this leads “to an understanding of resistance as creative forms of counter-conduct to repression or (power) production, individually as well as collectively” (Lilja & Vinthagen, 2014, p. 123). Resistance is shaped by power relations and, in turn, reinforces power relations (Lilja & Vinthagen, 2014); they are thus intertwined and mutually constitutive. In this section, I describe what various forms of resistance, and what strategies, are made possible and used to resist sovereign power, disciplinary power, and biopower.
Sovereign power is violent and extreme; it is “the forbidding power of law, violence and sovereignty” (Lilja & Vinthagen, 2014, p. 112). Through fear of punishment, sovereign power creates subordinate subjects (Lilja & Vinthagen, 2014, p. 112). Lilja and Vinthagen maintain that “[s]ince sovereign power is about claiming the monopoly to violently or forcefully repress certain behaviour and/or command other behaviour, resistance becomes a matter of breaking such commands or repressions” (2014, p. 113). In other words, the only ways to resist sovereign power is through illegal transgressive acts that break the rules of law, or undermining institutions that uphold the law. As this form of power expects obedience, resistance to it takes the form of disobedience.

Disciplinary power (anatomo-politics) is the power that trains, examines, organizes individuals in space and time, surveils and studies (Lilja & Vinthagen, 2014, p. 114); it is the power of institutions and discourses. It is a pedagogical program with the objective to instruct individuals on how best to live their lives through technologies of the self. It is disciplinary because it either rewards conformity and improvements, yet simultaneously disciplines deviation. In essence, it trains individuals to discipline and train themselves to become specific kinds of subjects. As such, there are various ways in which disciplinary power can be resisted. This can be achieved by: challenging discipline by avoiding discourses, rearticulating discourses to change their meanings (i.e. the recent phenomenon of certain social groups ‘reclaiming’ words or phrases, such as “nasty woman”), or undermining institutional control that attempts to shape and inform behaviours and practices; evading discipline through either physical or mental retreat (e.g. either removing oneself from society or feigning compliance while privately maintaining contempt towards disciplinary norms and values); or by negotiating one’s relationship to punishment-reward (i.e. construct the punishment as a reward), which undermines the purpose and function discipline (Lilja & Vinthagen, 2012, p. 114-115). However, Lilja and Vinthagen note that because disciplinary processes require techniques of domination of the self, resistance to discipline requires the modification or “the rewriting of one’s self” (p. 116).

Lastly, biopower is a nurturing form of power that organizes populations and collective sociality (biopolitics). Its main concern is not the individual, but rather the “body of a population (a nation, members of an organization, etc.) and its ‘health’ and ‘effectiveness’ as a totality” (Lilja & Vinthagen, 2014, p. 118). Biopower is a form of ‘social engineering’ or the management of health of entire groups, both physical and social. It operates from afar: through statistics, it
collects information and is able to guide the collective in a specified way through calculation of risk and direction for the management of risk. In this way, biopower is ‘pastoral’ as its interest is the nurturing and cultivation of the wellbeing of populations (Lilja & Vinthagen, 2014).

Because biopower is everywhere, it is difficult to resist. In order to be effective, biopower requires agency, liberty, and the ability for the individual to choose. Liberation, however, despite being a “process of resistance to…states of domination” (Lloyd, 2012, p. 31) is not a sufficient form of resistance to biopower because biopower does not operate through technologies of domination (Lloyd, 2012). As such, resistance to biopower in its current form is best described as “the struggle against relations of power” (Lloyd, 2012, p. 31). Strategies of resistance to this form of power can include leaving society and creating an alternative radical form of society, sharing and operating according to subjugated forms of knowledge (i.e. in relation to biomedical knowledge, this can take the form of discourses of ‘alternative medicine’), undermining technologies of biopower (i.e. refusing to take part in national surveys or national health programs, such as vaccination, etc.) (Lilja & Vinthagen, 2014, p. 121). In short, the form of resistance to biopower is essentially the opposite of what biopower tries to achieve: as biopower aims to develop productive forms of life, resistance to biopower challenges this objective by “developing non-productive forms of life and biological existence” (Lilja & Vinthagen, 2014, p. 121).

5  Foucault, Public Health & Medicine

Public health and medicine are central to governing populations and individuals. The wellbeing and biological corporeality of the individual and populations requires scientific knowledge of the body, and statistical calculations to understand the dispersion of disease throughout the population. This concern with the distribution of disease across populations and geographical space began in the nineteenth century (Lupton, 1995). Not only is the new contemporary approach to public health concerned with curing diseases, but now, more so, its concern is with the prevention of illness, giving rise to preventive medicine and public health education (Petersen & Lupton, 1996; Rose, 2001). As such, public health strategies include education and health promotion both at the population level (through campaigns) and at the level of the individual (i.e. during doctor-patient clinical encounters). In contemporary society, “power is
able to make pre-emptive interventions: eliminating the damage before it happens (Kullenberg, 2009, as cited in Lilja & Vinthagen, 2014, p. 123).

Through calculation of risk about health and safety, information about prevention and risk management, which includes instructions for practices and behaviours of self-care and self-surveillance, is communicated to citizens. Therefore in order to be effective, biopower, as exercised through public health and modern medicine, requires a specific kind of subject with a particular health identity: a biocitizen (Rose, 2001). A biocitizen is central to the project of the new public health. This is the responsible and rational citizen, one which takes up specific practices to maximize their own health not only for their own benefit, but for the benefit of society. The biocitizen is expected to sacrifice their own desires and liberties – to subjugate themselves – through practices of self-discipline and self-surveillance for the good of public health (Petersen & Lupton, 1996; Rose, 2001). They are supposed to become ‘enterprising’ individuals (Rose, 2001) or, according to Nettleton (1997) ‘consumers of health’. One of the ways in which the making of biocitizens is achieved under the ‘new public health’ is through biopedagogies. Biopedagogy relates to biopower; specifically, it refers to the “normalizing and regulating practices…associated with the body” that are intended to govern and regulate both individuals and populations (Wright, 2009, p. 1). It is the descriptions and pedagogies directed at individuals that offers “a number of ways to understand themselves, change themselves and take action to change others and their environments” (Wright, 2009, p. 2). In this way, biological life has become the central focus and concern of government.

5.1 Governmentality & Public Health

Foucault’s notion of governmentality is useful in understanding the ways in which the imperatives of public health are achieved throughout society, both collectively and by individuals, through the use of coercive and non-coercive strategies. Furthermore, it allows for an examination of the political and social functions that public health serves though its discourses and practices. According to this framework, public health, medicine and health promotion can be conceived of as “governmental apparatuses” (Lupton, 1995, p. 10), and the success of its ability to control populations can be attributed to the productive aspects of power that is exercised through technologies of domination and technologies of the self.

The governmentality framework has been used to examine public health by numerous authors,
some of which are presented here. Lupton (1995) explores the concept of health in public health discourse. She writes that health is no longer conceived of as a product of the social environment, but rather has become individualized. This new conceptualization resulted in the deployment of health promotion strategies aimed at individuals, as health, or lack thereof, has come to be viewed as a consequence of lifestyle choices made by the individual. Health, therefore, has become the responsibility of the enterprising self in liberal democratic societies (Rose, 1990; Rose & Miller, 1992) where the pursuit of health is not simply encouraged but expected. According to medical discourse, sickness is viewed as an individual choice. It reflects a lack of will to maintain a ‘natural state’ of good health on the part of the individual, a weakness in the form of a lack of self-discipline that results in exposing oneself to risks of disease, and a conscious choice to oppose expert knowledge through non-compliance with medical advice. By placing the responsibility of health and illness on the enterprising individual, the state of one’s body has become directly linked to one’s moral imperative and has become subject to moral judgment by medical experts and society. Moreover, when these discourses are taken up by individuals and internalized, these moral judgments are also turned upon the self. Thus in contemporary democratic societies, punishment for deviation from the norm (i.e. illness) does not originate from experts as an oppressive force, but rather from the self, and is delivered “through the mechanisms of self-surveillance, evoking feelings of guilt, anxiety and repulsion towards the self, as well as the admonitions of [an individual’s] nearest and dearest for ‘letting themselves go’ or inviting illness” (Lupton, 1995, pp. 10-11).

Castel (1991) uses governmentality to address the shift in the approach to preventive medicine from disciplining and therapeutically treating individuals according to the dangerousness they present to their own health as well as the health of others, to governing populations based on the potential risk that a certain dangerous attribute may arise. This new form of preventive surveillance is achieved through the accumulation of facts about the body which are then projected onto groups, labeling individuals as being ‘at risk’ according to a collection of abstract factors and, as a result, creating certain identities for them. In this way, risk has come to function as a technology of government in modern society through much more subtle forms of control than previously exercised.

Lupton (1999) expands on the notion of risk and includes an analysis of the ways in which risk functions as a technology of government in modern society. Specifically, she focuses on the role
of discourse, knowledge, institutional practices and strategies in establishing risk as a political rationality, and the types of subjectivities that are created in this process. From the perspective of governmentality, Lupton writes of risk as a “governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neo-liberalism” (p. 87). Various risks are identified, the information about them is collected and problematized, making it both calculable and governable (p. 87), which serves the function of making uncertainties, or in this case illness, more manageable. The rationalities of risk have changed in ways that require new and diverse forms of interventions and control, but are based on certain truths about how individuals ought to conduct themselves. Consequently, people no longer rely on the welfare state as a form of protection from risk; instead they increasingly rely on strategies of self-management, which are in line with political rationalities of neo-liberalism and self-enterprise.

Similarly, Petersen (1997) and Nettleton (1997) use Castel’s (1991) concept of risk to examine the ways in which risk management in contemporary society has broadened the reach of public health. Petersen lists “community development, personal skills development, the control of advertising ‘unhealthy’ and dangerous products, the regulation of urban space,…the intervention in workplaces, and the monitoring and periodic screening of sub-populations” (p. 195) as new areas of health promotion. This, he claims, has implications that include an increase in potential sources of risk, constructing more individuals and populations as ‘at risk’, an increase in the number of sites where strategies of governance are deployed, and a multitude of new forms of intervention. Like Lupton (1995), these authors emphasize the importance of self-governance as a strategy of the new public health and link it to the emergence of the privatization of risk management, resulting in the “commercialization of health welfare” (Nettleton, 1997, p. 220) and the construction of health ‘consumers’. However, the adoption of public health discourses on risk into these new areas results in constantly changing and often conflicting knowledges about risk, what constitutes it, how to manage it, and how best to conduct oneself in order to minimize it. Consequently the individual can never truly be certain about whether the ways in which they conduct themselves, even if it is in accord with any one expert, will truly guarantee their security.

The emergence of new public health strategies links with Rose’s (2007) analysis of the types of politics concerning human life today and in the future. He argues that contemporary technologies of government no longer focus on maintaining the quality of populations in an attempt to secure
the future of the nation through the elimination of illness and disease, as in the first half of the twentieth century. Rather, he poses that the focus of government in contemporary society falls on intervention and management of human life at the molecular level. Therefore Rose identifies a shift in both technologies and rationalities of government in modern society, which compel individuals to become responsible for their own affairs and security (p. 3-4). This includes health, where individuals no longer fulfill the roles of docile patients but are instead expected to become “active…consumers of medical services and products” (p. 4).

6 Applying Foucault’s Concepts to TB & Immigration Medical Surveillance

The ways in which public health, preventive health and health promotion have been conceptualized and analyzed using the governmentality framework are relevant for the examination of tuberculosis surveillance in the context of immigration. In this study, I will be examining the ways in which dominant discourses about immigration and TB construct the network of power, and how this in turn produces subjectivities and informs conduct of immigrants to Canada. I will do this by not only examining the different discourses in operation at the intersection of immigration, public health, and medicine, but also the ways in which immigrants navigate the process of immigration and medical surveillance and exercise power (i.e. through resistance or active participation) during various interpersonal encounters as they move through these processes. In this last section, I introduce the concept of discourse and explain how this will be relevant for my analysis in the present study.

6.1 Discourse

Discourse, as a concept, has been used and defined in diverse ways according to various theoretical traditions. The conventional understanding of the term ‘discourse’ is rooted in a linguistic orientation and refers to the use of language in talk and text, focusing on grammatical structure and semantics. In contrast, a poststructuralist notion of this concept, which I draw on for this study, is much more complex. In the following statement, Foucault imparts three general meanings to the word ‘discourse’:

…instead of gradually reducing the rather fluctuating meaning of the word ‘discourse’, I believe that I have in fact added to its meanings: treating it sometimes as the general domain of all statements, sometimes as an individualizable group of statements, and
Mills (2004, p. 6) analyzes these various ways in which Foucault speaks of discourse. The first definition is rather general and applies to any text or utterance that results in some social or material effect in the lived world. The second relates to a regulated group of utterances that are in some way structured, and, when combined, make it possible to speak of certain ways of being and ordering the world. The third refers not so much to the texts or utterances themselves, but rather, and more importantly, to the structures and rules that govern them. She goes on to specify that for Foucault, this understanding of discourse is inextricably linked with the notions of power, knowledge and truth, without which a discussion of discourse is simply not complete. This third definition, and one encompassing truth and the power/knowledge complex, is most relevant to the present study and requires further elaboration.

For Foucault, discourses are not reducible to mere language or “groups of signs” (Foucault, 2010a, p. 49), but are rather viewed as “systems of thoughts composed of ideas, attitudes, courses of actions, beliefs and practices that systematically construct the subjects and the worlds of which they speak” (Lessa, 2006, p. 285). They are also not just abstract ideas but rather highly regulated practices that function to produce and structure both social and material reality. Each society has its own groups of politically and historically situated rules that underlie various formations of knowledge, and each discourse represents a certain way of knowing about the world. As discourses are imbued with meaning, their circulation reproduces certain ideologies, structuring the world and “the ordering of objects” (Foucault, 2010a, p. 49) within it. Nothing can exist outside of it as discourse brings meaning to everything that we know and everything that we can know.

The circulation of dominant discourses reveals what a particular society holds to be ‘true’. While multiple discourses, or discursive frames, operate simultaneously at any given time, not all of them are given equal presence (Cheek, 2004); it is up to each society to determine which discourses, and thus which forms of ‘truth’ or knowledge, are legitimate. The ‘regimes of truth’ that structure discourse are produced by each society through the active exclusion and delegitimization of certain systems of thought. These in turn dictate who has the authority to speak the ‘truth’, and who does not (Foucault, 2010b, p. 73), and which formations of knowledge
are legitimate, and which are not. This point draws focus back to the notion of power and the ability of discourse to produce power effects, demonstrating that it is both productive and repressive as it simultaneously gives authority to some forms of knowledge while silencing others.

This struggle constructs discourses as battlefields. Every phenomenon or social situation is a site for the intersection of, and combat between, often competing discourses over the authority to define the phenomenon in question. Foucault (1975) describes this as “a strange contest, a confrontation, a power relation, a battle among discourses and through discourses…” where multiple battles can be “fought out at the same time” (p. x). In doing so, discourses are vying to secure status and legitimacy as they lay their claim to be speaking the truth on the subject. In effect, by speaking and acting according to certain discursive frames, various social actors can either seize power or be silenced in any given moment. As several discourses can exist simultaneously in one location, one discourse can simultaneously appear at various sites embedded in different institutions, occur in numerous texts and materialize as discrete forms of conduct. If, and when, these widely dispersed discourses all speak to and support the same form of knowledge, they are said to be a part of the same discursive formation (Hall, 2004).

6.2 Policy as Discourse

In this study, I conceptualize policy as both discourse and political technology (Shore & Wright, 1997). In my analysis of power relations, interpersonal encounters become the sites where the “regulatory powers of policy” (Shore & Wright, 2011, p. 2) are exercised. This conceptualization becomes useful for addressing both research questions, which examine how immigrants are governed during the immigration and settlement and IMS processes, as well as how they negotiate power during interpersonal encounters (as power relations are shaped by underlying rationalities and discursive fields). Foucault’s work on discourse allows for an examination of the social world by posing questions that are skeptical of the conventional social order and problematize current power formations. Thus the methodology I employ in this study is Foucauldian discourse analysis – a method of investigation which Smart (2002) summarizes as the “consideration of institutions, social practices and technologies of power and the self and their complex inter-relationship with forms of knowledge, in brief to the interface between non-discursive and discursive practices” (p. 47).
As Shore and Wright (2011) state, a “policy finds expression through sequences of events; it creates new social and semantic spaces, new sets of relations, new political subjects and new webs of meaning” (p. 1). As such, policies are not merely a collection of value-free texts and documents; rather, they are discourses and operate as such: they influence the ways in which people constitute themselves (and are constituted) as subjects, they inform individuals’ conduct, and they shape the very nature of social relations (Shore & Wright, 1997). Through this lens, I will go on to argue that the medicalization of the immigration process (i.e. the organization and procedural effects of the intersection of immigration policy, public health, and medicine), complicated by the articulation of these competing rationalities and discourses, produces different sites for the government and construction of immigrant subjects suspected of TB. It is at these sites, through the various interpersonal encounters between immigration applicants and TB health providers (both public health workers and TB clinicians), that biopower operates to regulate newcomers in ways that fit with state interests. As I will go on to show, the medicalization of immigration has an effect on all social actors involved: newcomers as well as TB specialists become embedded in a complex web of power that informs and guides their conduct in ways they may not be aware of. Consequently, the medicalization of immigration reinforces and further legitimizes the dominance of biomedical rationality that underpins immigration health screening and TB surveillance practices.

7 Chapter Summary

In this chapter, I have explained poststructural theory in general, as well as Foucault’s key concepts as they pertain to the present study. I first described how ‘governmentality’ is developed as a theoretical framework, which will be used to guide my analysis of the experience of new immigrants in undergoing immigration health screening and TB medical surveillance as part of the immigration and settlement process to Canada. Next, because as I will go on to show, in the context of immigration medical health screening and surveillance all three forms of power (sovereign, disciplinary, and biopower) operate, I have defined and discussed these in detail. I have also included a section to explain the various forms that resistance to power can take shape. Next, I situated public health and medicine as central to the government of individuals and populations in contemporary Western societies. I ended the chapter by explaining how these key concepts will be used in the present study.
Chapter 4
Methodology

1 Introduction

Qualitative methods have proved both meaningful and successful at exploring and addressing the contextual factors of the management and treatment of TB. Naturalistic inquiry (Tullis Owen, 2008) is most suitable to answer the proposed research questions because it, in part, allows for an examination of the daily realities and experiences of individuals undergoing Immigration Medical Surveillance (IMS) in the natural setting, taking into consideration their pre- and post-arrival conditions, the migration experience itself, as well as the structural conditions that shape these experiences for individuals.

In this chapter I outline my research design and provide a detailed description of the ways in which the study progressed, highlighting the most significant departures from the original study design and discussing their methodological implications. I present the methods of data collection and analysis, followed by issues of ethical relevance. After highlighting the limitations of this study, I discuss the strategies employed throughout the research process to achieve methodological rigour. This chapter is punctuated by reflexive annotations to account for the ways in which I have shaped this study in my role as researcher.

2 Research Design: Foucauldian Discourse Analysis

‘Discourse’ is a common concept to many disciplines and has been developed within various theoretical frameworks. This versatility has given rise to multiple ways in which discourse analysis is not only conceptualized but also operationalized (for more comprehensive discussions see Keller, 2013, 2012; Mills, 2004; Parker, 1999). Even the growing subdiscipline of Foucauldian discourse analysis is not constituted by a single methodology, nor does it focus on a single level of analysis (Diaz-Bone et al., 2007). Such diversity of approaches presents a challenge for qualitative social researchers as it leads to ambiguity around clear methods for the ways in which a Foucauldian discourse analysis ought to be done (Hodges et al., 2008; Cheek,
Parker (1999) offers some practical advice by proposing that the researcher applies various readings to the text maintaining a scrupulous sensitivity to language, which, when combined with interpretation, will enable the researcher to arrive at her own method. While there is no specific protocol dictating the way in which things “must be done”, the researcher has an obligation to explain “why they were done” (Cheek, 2004, p. 1148, emphasis in original). In this case, the overall scholarship of the research, as well as the theory that underpins it, is more significant than an explanation of the specific ways in which the approach was operationalized.

While most have refrained from developing discourse analysis as a method, in recent years sociologist Reiner Keller (2013, 2012, 2011) has formulated what he calls “The Sociology of Knowledge Approach to Discourse” (or SKAD). He describes SKAD not as a method but rather as “a research programme” (2011, p. 48) mainly concerned with understanding social relationships and the politics of knowledge. While this approach combines concepts and ideas from different theoretical traditions, Keller’s adoption and development of Foucault’s ideas about discourses and the social relations of knowledge makes this approach useful for guiding researchers through a Foucauldian discourse analysis. As such, some aspects of SKAD are applied to the present study.

In poststructuralist thinking, discourse is considered a framework that provides a set of rules to guide thoughts, speech, actions, and identities; it is conceptualized in relation to power, knowledge, and truth (Mills, 2004). Because discourses do not exist in isolation, they cannot be analyzed in isolation; instead, they must be studied in the context within which they exist. More importantly, the context itself, or the conditions that allow for discourse to continue to exist, as well as its effects, must be at the centre of the inquiry. A Foucauldian perspective allows the researcher to scrutinize the rules that establish some forms of knowledge to be considered true and others to be false. It is through the conceptual oscillation between the repressive and permissive effects of discourse that power relations can be interrogated using this approach.

Lastly, there is a focus on understanding what governs discourses – the conditions under which certain statements, or ‘truths’, come into being, how they are sustained and reproduced, how they operate throughout society, and what kinds of realities they produce for individuals (Lupton, 1992). This form of discourse analysis thus moves beyond an analysis of mere content as it “is concerned with the way in which texts themselves have been constructed in terms of their social
and historical ‘situatedness’” (Cheek, 2004, p. 1144). An unavoidable consequence of this thinking about discourse is the notion that language cannot be blindly accepted as value-free, neutral or apolitical. In fact, discourses have an objective as ‘truth’ plays a political and economic role in society (Foucault, 2010c, p. 74). The most commonplace talk, those aspects of language that seem most ‘natural’, does not in itself carry any intrinsic meaning but is rather assigned meaning by both the speaker and listener in varying contexts (Cheek, 2004). Therefore texts, as well as speech and other discursive practices, represent various aspects of reality and simultaneously help to maintain the very reality within which they exist or represent. As such, discourse analysis aims to question and problematize the unspoken and taken-for-granted assumptions upon which certain texts, talk, identities, and actions are based (Hodges et al., 2014; Lupton, 1992).

3 Setting, Recruitment & Participants

3.1 Summary of the Study

Recruitment and data collection took place between July 21, 2015, and May 15, 2016. Participants undergoing Immigration Medical Surveillance (IMS) for Tuberculosis (TB) were recruited from two sites: a hospital-based TB clinic (primary recruitment site; July 21, 2015 – April 22, 2016), and a Public Health unit (secondary recruitment site, April 4, 2016 – May 15, 2016), both located in Toronto, Ontario. The study was conducted in two phases: 1) observations of IMS TB clinic appointments; and 2) interviews with newcomers who were either in the process of, or had just completed, their IMS. Study participants were recruited for the observation phase from the TB clinic, generating 14 observations with 11 individuals. Interview participants were recruited from both the TB clinic and the Public Health unit; I conducted a total of 15 interviews with 13 participants. This study was reviewed and approved by Research Ethics Committees at three separate institutions: the University of Toronto, a Toronto hospital, and the Public Health Unit (Appendix A).

3.2 Choosing the Study Population & Primary Study Site

The original objective of the study, as well as the research questions, determined the choice of the primary study site and the general population of interest. While over the course of the study the research focus shifted from exploring the ways in which immigrants diagnosed with latent
TB infection (LTBI) experience receiving their diagnosis in the context of IMS to exploring the overall experience of undergoing the IMS process in the context of immigration and settlement, the target population for the study remained the same.

In consultation with public health officials, a specialized TB clinic was determined to be the most direct, effective and convenient site where new immigrants undergoing IMS could be accessed. Upon consultation with the clinic director, I chose an urban hospital-based TB clinic in Toronto, Ontario (referred to as ‘the clinic’ henceforth) as the recruitment and primary study site. I met with the medical director of the clinic several times to familiarize myself with clinic procedures and to better understand how newcomers moved through the IMS process. This information provided insight into the ways in which the clinical context shapes immigrants’ experience of the IMS process, and served as a basis for: 1) refining the inclusion criteria; 2) choosing a sampling strategy; 3) developing recruitment procedures; and 4) generating the interview guide.

The objective of the present study is to better understand the ways in which newcomers engaged with discourses around immigration, medical surveillance, TB, their resulting diagnoses and potential treatment. I determined that characteristics such as immigration category, age and life stage, sociocultural background, and English fluency were all important factors influencing the ways in which individuals negotiate power at various stages of the immigration and medical surveillance processes. The category of ‘immigrant’ is incredibly diverse and reflects countless migratory pathways of human movement across national borders via documented and controlled channels (constituting authorized or ‘legal’ entry). While my initial objective was to recruit a homogeneous group of immigrants (i.e. permanent residents), recruitment challenges did not allow me to meet this objective. As a result, while I focused on primarily recruiting permanent resident applicants and excluding refugees (based on the complexities associated with their life circumstances prior to migrating to Canada, as well as their exemption from inadmissibility on health grounds [Government of Canada, 2016]), I included both permanent and temporary residents, as well as one refugee. The age group of participants was chosen to represent the population with the highest reported incidence of TB, as well as to include adults of working age. Other inclusion criteria for participant selection reflected the demographics of the patient population in terms of ethnicity, languages spoken, and English fluency.
3.3 Sampling

Criterion purposeful sampling was used to identify prospective candidates for the study. This sampling approach is used to select cases that meet specific pre-determined criteria based on their potential to yield relevant and rich information regarding the topic or phenomenon of interest (Patton, 2002a). This strategy is similar to theoretical sampling in that there is a focus on social or cultural features or other specific attributes that are likely to be of analytical significance (Patton, 2002a; Green & Thorogood, 2009).

Participation was restricted to a narrowly defined subgroup of immigrant patients attending the clinic for their first two IMS appointments (Table 4.1). Initially, this included male and female PR applicants aged 18-55 years, fluent in Mandarin, Cantonese, Hindi (the three most commonly spoken languages among immigrant patients at the clinic), or English. Once a diagnosis would be made, only those individuals with confirmed LTBI would be selected to remain in the study. Over time, however, it became apparent that these inclusion criteria, as well as the research focus (e.g. LTBI), were too restrictive for the clinic patient population, and it became necessary to change the inclusion criteria in order to increase the pool of eligible candidates. After consulting with my supervisory committee, the inclusion criteria were revised in October 2015 as follows: 1) immigration categories now also included refugees, international students, and temporary foreign workers (as long as they intended on staying in Canada permanently); 2) the age limit was increased to 60 years; and 3) while the aim to include both English and non-English speaking participants remained, recruitment was opened to immigrants of all ethnicities and language groups. Moreover, as the research focus was also revised at this time, all IMS patients irrespective of diagnosis (e.g. LTBI, active TB, no TB, and other) became eligible for the study. Consequently, while I continued to purposefully select those individuals who met the new demographic, social, and diagnostic inclusion criteria, for pragmatic reasons I had to adopt a convenience sampling strategy, referred to as “purposeful convenience sampling” (Patton, 2002a), for the remainder of the study conducted at this site.

Additionally, I included a purposefully selected convenience sample of IMS clients recruited from a Public Health unit starting April 4, 2016, until May 15, 2016. At this site, men and women who met the following criteria were invited to participate in the study: aged 18-60 years, PR applicants (in economic or family class) of all ethnicities / language groups who have
### Table 4.1 Participant Inclusion Criteria & Sampling

<table>
<thead>
<tr>
<th><strong>RECRUITMENT SITE</strong></th>
<th><strong>TB CLINIC</strong></th>
<th><strong>PUBLIC HEALTH UNIT</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>RECRUITMENT SITE</strong></td>
<td><strong>ORIGINAL</strong></td>
<td><strong>REVISED</strong></td>
</tr>
<tr>
<td><strong>Research Focus</strong></td>
<td>Experience of LTBI diagnosis and treatment in the context of IMS during immigration and settlement process</td>
<td>Experience of IMS for TB in the context of immigration and settlement process</td>
</tr>
<tr>
<td><strong>Inclusion Criteria</strong></td>
<td>- PR immigration applicants (economic and family class) - male and female - age 18-55 years - Language groups: English, Mandarin, Cantonese or Hindi - LTBI diagnosed</td>
<td>- all immigration applicants and all classes (as long as planning on settling in Canada permanently) - male and female - age 18-60 years - any language groups / ethnicities - any diagnosis (LTBI, active TB, no TB)</td>
</tr>
<tr>
<td><strong>Exclusion Criteria</strong></td>
<td>- Refugees, temporary migrants (i.e. international students, foreign workers, visitors etc.) - active TB or no TB/LTBI diagnosed</td>
<td>- temporary migrants not intending to stay in Canada permanently</td>
</tr>
<tr>
<td><strong>Sampling Strategy</strong></td>
<td>Criterion Purposeful Sampling</td>
<td>Purposeful Convenience Sampling</td>
</tr>
</tbody>
</table>

completed the IMS process; refugees and other temporary migrants (i.e. international students, temporary foreign workers, visitors etc.) were excluded.

### 3.4 Primary Study Site: The TB Clinic

#### 3.4.1 Research Setting

The clinic served as the primary recruitment and data collection site from July 21, 2015 to April 22, 2016. The clinic operates twice per week 8:30am-12pm; it is staffed by a total of 6
respirologists (including the clinic director), a TB case manager / nurse practitioner, 2 public health nurses, a respirology nurse, administrative personnel, and 2 respiratory therapists. Up to 3 resident doctors as well as an occasional nursing student attend the TB clinic at a time. In total, there are anywhere between 5 and 9 clinical staff members (a respirologist, the case manager, and at least one nurse, a receptionist, and a respiratory therapist; this total excludes resident doctors who may or may not be present) working at any one time at the clinic, and a patient may interact with up to 6 different clinicians during each visit.

The clinic provides specialized TB care and services to hundreds of patients annually, mostly immigrants, refugees, and homeless. All patients attending the clinic are there by referral. Most common referrals are made by primary care physicians for assessment of positive skin tests, often, but not always, in the context of workplace or school TB screening. Other referrals are made by the public health department or by physicians for the purposes of contact tracing or medical surveillance, some in the context of immigration. Patients seen in the context of IMS are typically suspected of having active TB disease as indicated by an abnormal chest x-ray or previous history of TB detected during the Immigration Medical Exam (IME).

These patients require a minimum of two appointments in order to receive “medical clearance” for their immigration application. During the initial appointment, the patient undergoes diagnostic testing as well as a medical assessment (including a health history and physical examination). The patient returns 8 weeks later for a follow-up appointment once the results of the tests are known and active TB can be either confirmed or ruled out. If the patient is diagnosed with active TB they must complete treatment in order to receive “medical clearance”; the individual remains under the care of the clinic for the duration of the treatment. If, however, no active TB is detected, the patient is considered to have fulfilled their immigration medical requirement. At this point, LTBI may be diagnosed and the patient must decide whether they will begin prophylactic treatment or not. Whether the individual will remain under the care of the clinic staff and return for future appointments or not is partially dependent on this decision.

3.4.2 Recruitment

The recruitment strategy was negotiated with the clinic director and the TB case manager in compliance with the hospital REB. While immigration applicants undergoing IMS were the focus of the study, observations of clinic appointments also involved the clinicians and thus
required their consent. Prior to starting recruitment and data collection, the consent form was distributed to the clinic staff via email from “within their circle of professional contact” (Hospital REB Feedback, Jan. 6, 2015) (please refer to Appendix B for the Clinic Staff Consent Form). Staff members wishing not to participate in the study were assured that their employment or professional standing would not be affected by this decision; they would simply not be directly involved in the assessment of patients enrolled in the study. All TB clinic staff agreed to take part in the study.

Immigrant participants were recruited in 3 concurrently running stages. Each recruitment stage corresponded with a participant’s progress in the IMS process, qualifying them for a specific phase of data collection. Participants recruited at **Stage 1** were those attending the TB clinic for their *initial appointment* and were only consenting to participate in the observation phase of the study at this time. Participants recruited at **Stage 2** were returning to the clinic for their *first follow-up appointment* and were simultaneously consenting to partake in both the observation phase and, after having received their diagnosis, in the interview phase of data collection. In September 2015, **Stage 3** of recruitment was added. Participants recruited at this stage were either attending the TB clinic for further follow-up appointments or were identified through retrospective chart reviews; these patients either completed, or nearly completed, the IMS process. Consent at Stage 3 was sought for the interview phase of the study only (Table 4.2).

### Table 4.2  Recruitment Schedule

<table>
<thead>
<tr>
<th>Recruitment Stage</th>
<th>Participant Progress in IMS Process</th>
<th>Data Collection Phase</th>
<th>Recruitment Site (Date)</th>
<th>N Participants Recruited (n research encounters)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stage 1</strong></td>
<td>Beginning (Initial clinic appointment; begin diagnostic testing)</td>
<td>Observation</td>
<td>TB Clinic (Jul. ’15 – Apr. ’16)</td>
<td>5 (5)</td>
</tr>
<tr>
<td><strong>Stage 2</strong></td>
<td>Middle (1st follow-up appointment; receiving diagnosis)</td>
<td>Observation &amp; Interview</td>
<td>TB Clinic (Jul. ’15 – Apr. ’16)</td>
<td>9 (9 observ’s; 8 interw’s)</td>
</tr>
<tr>
<td><strong>Stage 3</strong></td>
<td>End (Completion or near completion; medical clearance)</td>
<td>Interview</td>
<td>TB Clinic (Sep. ’15-Apr. ’16)</td>
<td>3 (3)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Public Health Unit (Apr.-May ’16)</td>
<td>2 (3)</td>
</tr>
</tbody>
</table>
Commencing in July 2015, the clinic staff began screening incoming patients’ files prior to their scheduled appointments to identify prospective participants for the study (though a misunderstanding of recruitment criteria led to some candidates being incorrectly identified through this process); those considered to meet the inclusion criteria received a consent and information package (please refer to Appendix C) in either English or Chinese from the administrative staff at check-in. (This information was also translated into Hindi to correspond with the initial population of interest, but it was later discovered this translation was inaccurate. Due to restrictions on time and resources a second translation could not be performed and consequently the Hindi version of the consent form was discontinued). Candidates were asked to review the information package while they completed any diagnostic testing prior to the start of their appointments. Once the clinician called the patient into the exam room to begin the appointment, she/he inquired whether the patient had questions about the study and if they were interested in participating; most people were not interested and declined. The few individuals willing to participate, or those with further questions, met with me personally. I explained the study in detail and addressed any questions or concerns. For non-English speaking candidates, this process was mediated with the help of an interpreter through Language Line, the telephone interpretation services used in the clinic. After confirming that the candidate met all the inclusion criteria, I obtained written consent from the patient and included them in the study. These procedures were followed for all three stages of recruitment. In Stages 2 and 3 where participants were recruited for the interview phase, arrangements for the meeting were made after the clinic appointment finished; interviews were scheduled at a time and location most convenient for the participant.

3.4.3 Recruitment Procedures: Challenges & Amendments

In the first two months of recruitment and data collection I attended all 19 clinics that were held. Following the sampling and recruitment procedures outlined above, out of 14 prospective candidates identified by clinic staff during this time only 2 were successfully recruited, resulting in two observations (one incomplete due to recruitment error) and one interview. The poor recruitment rate was attributed to two causes: 1) the restrictive inclusion criteria, and 2) the recruitment procedures. As qualitative inquiry is an iterative process, several amendments had to be made to the research design in response to various challenges that were encountered over the course of the study. Only the most significant changes will be discussed in detail in this chapter.
The recruitment procedures for this study were mandated by the hospital REB in accordance with the existing institutional policies and practices. These procedures, however, were inappropriate for the patient population referred to the clinic for IMS. First, the REB instructed that the consent forms must include very specific and detailed information (as outlined in a 34-page “Guidelines” document). This resulted in a very lengthy document which was not easily accessible by, or suitable for, the population of interest in this particular study (e.g. vulnerable population with limited language fluency). Second, by mandating that clinic staff take on sole responsibility for participant selection and introduction of the study to prospective candidates, the REB unwittingly imposed the role of ‘gatekeeper’ on clinicians, which consequently had damaging effects on recruitment.

As the name suggests, a gatekeeper can either facilitate or restrict the researcher’s access to the study population (Green & Thorogood, 2009); therefore, in their position as mediators, gatekeepers have a great amount of social control over a study. In the present study, the conflict between the clinicians’ primary aims of providing service and medical care, as well as time constraints and a high turnover rate of new medical residents impaired participant recruitment. My location as a student and “visiting researcher” in the institution left me with little social power to negotiate the nature of the clinician gatekeeper’s involvement in the recruitment process. (For a more detailed analysis, please refer to Appendix D). Ideally, I would have advocated for a more involved approach where clinicians introduced the study to the participants personally (rather than simply presenting them with an information package) and engaged research candidates in a conversation, framing the study in a way that was more in line with positive recruitment outcomes for vulnerable populations. However, as a visiting student researcher, I was in no position to dictate additional responsibilities to an already busy staff that would take away from their priorities of providing medical care to patients.

In order to address this situation, in September 2015, I requested and was granted REB approval to access patient charts, which had two important implications. First, it allowed me to screen incoming patients and correctly identify those candidates who fit the inclusion criteria. While this increased the accuracy in the selection of potential participants, it did not change the recruitment procedures or improve the recruitment rate as clinicians remained the gatekeepers for the time being. Second, in light of the shortage of eligible study candidates attending the clinic, I began a retrospective chart review of patients who attended the clinic for the purpose of IMS.
within the previous 2 years to recruit for the interview phase of the study (implementing Stage 3 of recruitment). After reviewing almost 200 charts, only fourteen individuals were selected. The administrative assistant telephoned all the candidates to extend an invitation for participation with no success: many former patients could not be reached (i.e. change of address / phone number etc.), and others declined to take part in the study. While retrospective chart review was abandoned as a recruitment strategy, incoming clinic patients were screened for inclusion in Stage 3 of recruitment for the remainder of the study.

After another month, the hospital REB agreed to amend the recruitment procedures, permitting me to approach research candidates personally. This modification was beneficial to the study; by freeing clinicians from the responsibility of recruitment, the institutional level barrier between the staff and the research was removed, granting me greater control over recruitment and consent. Beginning October 23, 2015 patients were no longer given the information and consent package by the receptionist to review for themselves. Instead, after checking in, I personally introduced and explained the study to prospective participants in a private setting. This approach not only gave patients an opportunity to ask questions or voice their concerns right away, but also, and more importantly, enabled me to establish rapport with potential participants even prior to obtaining consent, which had a significant impact on their decision making process. For instance, one participant mentioned that he felt I was honest with him and I “spoke…from the heart”, which, to him, influenced his decision to take part in the study. He elaborated: “if I didn’t like you, I would tell you…I would let you say your piece and then leave, go my own way” (Michael, March 2016). This change in the recruitment procedures was critical and resulted in an increase of the recruitment rate from 25% to 55%.

3.5 Secondary Study Site: The Public Health Unit

After three months in the field and only 2 participants recruited for interviews, it was necessary to further revise the recruitment strategy. In October 2015, the decision was made to add a secondary recruitment site in consultation with my supervisory committee; considering access to the population of interest, time required for obtaining REB approval, and probabilities of success with recruitment, a Public Health unit was perceived to be the best option.
3.5.1 Research Setting

The Public Health unit oversees the TB medical surveillance process and, as such, maintains centralized records for all IMS clients; approximately 1,500 CIC medical surveillance referrals are made to this unit annually (Greenaway et al., 2011). Upon completion of IMS, public health authorities notify CIC that the applicant has complied with the medical surveillance condition of entry to Canada and has received medical clearance. Each client is mailed an official discharge letter from the local public health unit notifying him or her that they have completed, and are being released from, the TB Medical Surveillance Program.

3.5.2 Recruitment

The study underwent ethics review at the Public Health institution and received approval in late March 2016. The recruitment procedures were devised in consultation with Public Health staff following the directives of the REB (for a detailed discussion on the tensions and challenges stemming from REB governance in the context of this research, and the effects this had at various stages of the study, please see Appendix D). Participants were recruited between April 4 and May 15, 2015 for the interview phase only (Recruitment Stage 3). All clients who were being discharged from the TB Medical Surveillance Program in April 2016 were considered for the study; public health staff identified 53 prospective candidates (for inclusion criteria please refer back to “Sampling” section or Table 4.1). A research flyer (Appendix E) was mailed to all eligible candidates along with their discharge letters. Recipients were instructed to contact me if they had any questions about the study or if they were interested in participating. Two individuals responded to the flyer by telephone and agreed to participate in the study; arrangements were made at this time to meet for interviews. Following our conversations I emailed the Information and Consent package (Appendix F) as well as a Socio-Demographic Questionnaire (Appendix G) to the participants; both documents were reviewed with the respondents in person and written consent was obtained prior to starting the interview.

3.6 Research Participants

Out of sixteen individuals who took part in the study, fifteen were undergoing IMS (one couple, Mary and Andrew, were interviewed together; while Andrew was the only one undergoing IMS, his participation in the study was contingent upon Mary’s presence and participation in the
interview. Because Mary was not an immigration applicant, nor was she undergoing TB medical surveillance, her demographic information is not included in this section). All participants were referred for IMS in Canada as a result of an abnormal chest x-ray detected during their routine IME. Nine women and six men between the ages of 21 and 59 took part in the study, with most participants falling in the 25-35 age range. The majority of research participants emigrated from lower-middle income countries (five from the Philippines, two from India, one from Myanmar [via Malaysia]), followed by upper-middle income countries (two from China, and one each from Peru, Russia and the Caribbean), and high-income countries (one participant from France and one from USA) (The World Bank, 2016). This group is representative of the typical population with the highest incidence of TB in Toronto with respect to age, ethnicity (Toronto Public Health, 2014) and region of origin (Khan et al., 2015), with the exception of the two participants from high-income nations (when combined, immigrants from USA and Western Europe represent only 2% of all post-arrival IMS referrals in Canada [Khan et al., 2015]).

The study sample included ten Permanent Resident applicants (one applying as a principal applicant, eight as a spouse or dependant; one did not provide information), three International Students, one Government Sponsored Refugee, and one Temporary Foreign worker. Most participants were married (or in common-law relationships) and lived with their partner. While five participants had children, the children of two participants remained in their home country (Andrew and Fiona). At the time of recruitment, the length of time since arrival in Canada ranged from 3 months to 6 years (average was 18 months); the majority had arrived within the past 24 months of which eight were still within their first year. Ten participants spoke English fluently, three had poor English fluency, and two did not speak English. All but one participant (Jergua) received a medical diagnosis in the context of the IMS process. Six had no TB. In this group, one participant was never exposed to TB (John), three had scarring from previously treated TB disease (Awngshayi, Michael and Stacey), and three (David, Andrew and Michael) were diagnosed with Mycobacterium avium complex [MAC], a “cousin” of TB. Four participants had suspected LTBI but chose not to pursue (Sunny, Margaret, Jane), or were not given (Zara), a definitive diagnosis. The remaining four participants were diagnosed with LTBI, of which two (Eve and Fiona) began chemoprophylaxis; the others (Memphis and Angela) either declined or were unable to begin treatment.

Participants’ immigration status affected their employment in Canada to varying degrees. Almost
half of the research participants were not employed at the time of the study; this included three international students, two new mothers, and two applicants without a valid work permit (though one of these two was engaged in undocumented work). The remaining participants had a wide variety of occupations ranging from unskilled manual labour to highly skilled professional jobs. The level of education varied widely among the group as well; some had only partial secondary school education (Andrew and Stacey) while others completed post-graduate degrees (John, Angela, Margaret and Zara). Most, however, had some college or university education. These sociodemographic characteristics are summarized in Table 4.3.

3.7 Data Generation

Sources of data necessary to conduct Foucauldian discourse analysis should include samples of written or oral texts generated through various conventional techniques of data ‘collection’ used in qualitative studies (Cheek, 2004). Given the phenomenon of interest, I was interested in samples of spoken texts to understand how discourses about TB and immigration were used mainly by newcomers (but also by clinicians) in the context of a medical institution, as well as in day-to-day life. Furthermore, I aimed to better understand what effects these discourses have on newcomers’ social and material reality, as well as their physical and mental health.

Data were generated through observations of clinic appointments and interviews with IMS clients. I screened approximately 2,000 patients (excluding retrospective chart reviews) scheduled to attend 83 of the 88 clinics held during my time at the primary study site. A total of 41 invitations were extended to prospective candidates at the clinic, with an additional 53 invitations at the Public Health unit; sixteen participants took part in the study. Due to the iterative nature of the recruitment process, individuals were recruited at various, sometimes multiple stages, taking part in either the observation or the interview phase, or both. Three participants were involved in observations only (Jergua and Margaret recruited at Stage 1; Angela recruited at Stage 2), and five took part only in interviews. Eight individuals participated in both observations and interviews, of which three provided written consent twice (at both Stages 1 and 2). For a summary, please refer to Table 4.4.

The tools used for gathering and recording information in this study included field notes, reflexive memos, analytic memos and transcription. During data generation, the purpose of field notes (as employed in this study during both clinic field observations and observations of clinic
### Study Sample: Socio-Demographic Characteristics

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>DISTRIBUTION WITHIN SAMPLE</th>
</tr>
</thead>
<tbody>
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<td><strong>Age / Sex</strong></td>
<td></td>
</tr>
<tr>
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<td>- MAC:</td>
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<td>- not TB-related:</td>
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* Data not available for all participants
+ Information was changed to protect participant’s identity
Table 4.4  Respondent Participation by Phase & Recruitment Stage

<table>
<thead>
<tr>
<th>Data Collection Phase:</th>
<th>OBSERVATION</th>
<th>INTERVIEW</th>
</tr>
</thead>
<tbody>
<tr>
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<td>Stage 2</td>
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<tr>
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<tr>
<td>Jane</td>
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<tr>
<td>Eve</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sunny S.</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Memphis</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Fiona</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Michael</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Angela</td>
<td>-</td>
<td>Yes</td>
</tr>
<tr>
<td>Awngshayi</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Andrew (&amp; Maria)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Zara</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Stacey</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

Notes: * Data for these appointments are incomplete as the researcher was unable to attend and observe the entire appointment.
1. The ordering of participants in this table does not reflect the chronological order of recruitment.
2. Participants are identified by pseudonyms.

appointments) is to record observed information (i.e. what can be seen, heard, smelled, physically felt, etc.), while memos involve recording ideas, insights, or hunches both in and out of the field (Firmin, 2008). I further distinguished between reflexive and analytic (or theoretical) memos; reflexive memos focus on personal musings and impressions about social encounters, while analytic memos are a record of how these encounters can be interpreted theoretically in the context of the study (Roulston, 2008). Transcription involves the process of transforming research conversations, such as clinic appointments and interviews, from audio-recorded form into textual material (transcripts); the transcripts themselves become the primary data used for analysis in qualitative research (Poland, 2008, p. 885). Additionally, because interpreters and translators were central to the co-construction of data and feature in the data in some research
encounters, they are also conceptualized and discussed here as tools for data generation. Due to the inherent language barrier between the researcher and the study population, the help of interpreters and translators was essential; their roles in research, however, differed and are distinguished as follows (Squires, 2008): Professional interpreters provided oral translation between patients and clinicians during clinic appointments (Angela), as well as between research participants and the researcher during interviews (Andrew and Maria). After data generation was complete, a student volunteer assisted in her role as translator, providing assistance with translating and culturally interpreting the audio recorded data that was generated during the clinic appointment for which interpretation services were used (Angela).

3.7.1 Observations

Observations took place at the TB clinic between July 2015 and April 2016. Data were generated through non-participant observation (Green & Thorogood, 2009), or what Miller and Crabtree (1999) call “background observation”. The key difference between participant observation and non-participant observation, or background observation, is the focus on watching and analyzing behavioural phenomena unobtrusively with minimal participant engagement where the researcher assumes the position of a spectator. This is considered to be the most useful form of data collection in a health care setting particularly when the social phenomenon of interest is the naturally occurring patient-health care provider consultation because it is less disruptive to the natural flow of events in the clinic (Green & Thorogood, 2009; Miller & Crabtree, 1999).

Over the course of the study, I attended 35 TB clinics and spent a total of 110 hours in the clinic. A large proportion of this time was dedicated to conducting field observations of the clinic itself. The purpose of these field observations was to contextualize participants’ experiences as observed in clinic appointments. I began field observations with a broad focus, aiming to familiarize myself with the clinic setting, the clinicians, and the routine practices that take place outside of patient appointments. After several days of unfocused observation, I employed “sensitizing concepts” (Patton, 2002a) informed by the theoretical framework of this study, focusing my observations on the ways in which power is operationalized at the clinic through discourses (both in talk and action) about newcomers as IMS patients. The clinic observations produced approximately 150 pages of hand-written notes.

I attended and observed a total of fourteen clinic appointments involving eleven patients. The
average recruitment rate for observations during this time was approximately one for every six clinics that were held (or two observations every three months). Five participants were recruited at the time of their initial clinic appointment (Stage 1), of which three returned approximately two months later and took part in the observation of their follow-up visits (Stage 2); six participants were recruited at the time of their follow-up visit only (Stage 2). Two of the observations (Jane-Stage 1; Eve-Stage 2) captured only a fragment of the clinic appointment due to clinician recruitment error (clinicians were too late in notifying me that their patients wanted to take part in the study). One additional participant consented to participate but had to be withdrawn from the study because the appointment was conducted in my absence; no data was collected for this individual.

Both the initial and first follow-up appointments for IMS were included as both were relevant to the study objectives. During the initial visit, patients learned about the series of steps they had to undergo before obtaining the necessary medical clearance for CIC, as well the implications this had for their immigration process. At the time of the follow-up visit, patients learned their diagnoses, made treatment decisions, and were further informed of the ramifications of their test results and treatment on the status of their immigration application. The duration of clinic appointments ranged from as little as 7 minutes to almost an hour. Some participants attended their appointments alone, while others were accompanied by family or friends. Written consent was obtained from each participant prior to the start of the appointment. All participants were asked to complete a Socio-Demographic Questionnaire before observations began (Appendix H). In addition to providing descriptive statistics, this information not only helped to guide the interview process as interview questions were tailored to each individual’s unique situation, but also provided context for analysis of interview data.

All observed clinic appointments were audio recorded. I made notes of non-verbal actions and interactions that took place during the assessments (see Observation Data Sheet, Appendix I). Following Loftland (1971, as cited in Green & Thorogood, 2009, p.162), my observations and notes focused on capturing the following features: setting (e.g. the examination rooms); social environment / social relationships (i.e. how people interacted, who was interacting with whom, the organization of bodies in time and space, the direction of communication, who dominated the conversation etc.); and the movement of bodies / activities / acts (i.e. how people moved within the space, who was present, body language, what functions each person performed, other non-
verbal acts such as crying etc.). The time at which these instances occurred during the appointment were “anchored” to verbal utterances and were combined and included as notes in the written transcripts. Following the appointments, detailed field notes were either written or audio recorded, focusing on the nature of my interaction with the participant before and after their appointment. Analytic and reflexive memos about this interaction were also included.

All audio-recorded observations were transcribed, producing a total of 140 pages of appointment observation text. I made all attempts to capture a verbatim account of not only the speech but also the overall interaction that took place during the clinic appointment. In order to develop a syntax and style that captures the nature of the interaction as best as possible (Poland, 2003), I personally transcribed the first few observations. This also allowed me to familiarize myself with the data and begin to think analytically about it. The majority of the observations were transcribed by a professional transcriptionist. I personally verified all professionally-transcribed text for accuracy of both content and other nonverbal communication, such as chronemic (the pacing of speech and pauses) and paralinguistic (changes in pitch, tone, and voice quality) communication (Gorden, 1980), and to maintain consistency in syntax. The one clinic observation (Angela) involving an interpreter was transcribed with the assistance of the translator who not only translated the Mandarin spoken during the appointment into English, but also helped with cultural interpretation of the interaction between the participant and interpreter; her notes were incorporated into the data and included in the analysis.

3.7.2 Interviews

Fifteen semi-structured interviews were conducted with twelve participants between September 2015 and May 2016 (see Table 4.4). The interview approach most compatible with the objectives and theoretical perspective of the present study is individual in-depth interview. This interview style “is one that allows the interviewee enough time to develop their own accounts of the issues important to them” (Green & Thorogood, 2009, p. 94). This form of interview privileges and explores individual accounts of events, acknowledging that each account is equally valid. Moreover, a comparison of accounts gathered through in-depth interviewing can be used effectively to develop “a theoretical understanding of underlying structures of beliefs” (Green & Thorogood, 2009, p. 95), making this interview approach ideal for discourse analysis.

The length of interviews varied from 45 minutes to 3 hours. Follow-up interviews were
conducted with three participants (John, Awngshayi and Stacey) whose stories and narratives exceeded the time they had allotted for the first interview. For the ten participants recruited from the clinic, interviews were scheduled approximately one week after meeting at a time and location most convenient for participants. Because the interview location affects participants’ positionality as well as their level of comfort and disclosure around sensitive topics (Adler & Adler, 2003; Elwood & Martin 2000), the hospital was intentionally excluded as an interview site. Most interviews were conducted in-person at coffee shops, libraries, private meeting rooms both on- and off-campus, empty building lobbies or floors, and community health centres in different parts of the Greater Toronto Area (GTA). When face-to-face meetings were not practical for participants, I conducted interviews over the telephone (Memphis and Fiona) or via Skype (Jane). With the exception of Andrew (who was interviewed along with his wife, Maria, and required the assistance of a Tagalog interpreter), all interviews were conducted with a single interviewee in English.

The interview encounter was structured into three sections: the informal opening conversation, the formal question and answer period (the interview itself), and the informal closing conversation. The interview encounter began the moment the participant and I met. I engaged each participant in informal conversation on a range of topics in order to develop better rapport and help ease the participant into the interview. I asked about their day, chatted about the weather, living in Toronto, and so on. Once I felt we had reached a certain level of comfort after this icebreaker, I obtained written consent from those who did not already provide it.

The formal part of the interviews followed a guide that was developed using Green and Thorogood (2009), Hsiung (2010), Kelly (2010), Kvale and Brinkmann (2009), and Rubin and Rubin (2005) (see Interview Guides Appendix J). The questions (along with suggested probes and follow-up questions) served as a general template; this template was slightly revised and tailored to each participant prior to the interview, taking into consideration any background information I may have already gathered about them (i.e. through Socio-demographic questionnaires, clinic appointment observations, conversations etc.). Furthermore, the order of questions or some of the questions themselves were adapted ad hoc to ensure relevance and to maintain natural flow and continuity of the conversation. Given that “interviews conducted for the purposes of discourse analysis differ from others in that respondents are allowed greater rein to talk around a subject than is normally the case” (Lupton, 1992, p. 146), I intended to engage
individuals in more of a conversational exchange. While the interview guide provided a structure for the encounter, I encouraged my participants to elaborate on each question as they saw fit. I quickly realized, however, that many participants found this challenging. Most notably, I discerned that the focus of the research (e.g. TB and medical screening during immigration) imposed a somewhat limiting frame for participants in terms of discussing their experiences, and most individuals required significant probing and encouragement to talk about other aspects of their social life (i.e. immigration, interpersonal relationships etc.) that were still relevant, albeit less directly, to the topic of study. Eventually I prefixed each interview with ‘instructions’ or ‘guidelines’ for ‘how’ to answer the questions, directing participants to feel free in discussing their experiences outside the context of TB and to elaborate as much as they can. I assured them that their responses would still be relevant and, if I felt they deviated too far from the topic, I would inform them.

After the formal interview period, an informal closing conversation took place. While in most cases this conversation was brief (only a few minutes), some participants remained and talked for up to an hour or longer (John, Awngshayi and David). Most participants took this time to ask specific questions about the study; some were also curious about me personally (as an immigrant, student, researcher, mother, etc.). A few participants also further elaborated on their experiences, which helped to contextualize their formal responses. Field notes detailing the whole encounter from beginning to end were made immediately following each interview; this included reflexive (e.g. impressions about the participant and our interaction) and analytical memos.

Fourteen of the fifteen interviews were audio recorded and transcribed following the same method as described in the Observations section. Out of perceived fear of potential persecution by authorities, Andrew declined to have his interview audio-recorded; instead, I typed the couple’s responses on my laptop throughout the interview. Furthermore, an interpreter was assisting during Andrew and Maria’s interview. While the extra time required for translation during cross-language interviewing is typically perceived as a methodological challenge given that it disrupts the natural flow of the interview (Green & Thorogood, 2009), this slow pace was actually beneficial as it provided sufficient time for me to write down the participants’ responses. I personally transcribed four of the audio-recorded interviews to familiarize myself with the data (John - Interview 1, Eve) as well as for ethical reasons (Awngshayi - Interviews 1 and 2); the remaining ten were professionally transcribed, and were checked by me for accuracy prior to
Data Analysis

The analytic approach used in this study was Foucauldian discourse analysis. As discourse analysis is an approach rather than a method, it generally lacks a set of specific rules or steps to follow during analysis (Cheek, 2004). Although some have tried to develop a methodological template to provide a structure for the analytic process, my analysis followed Cheek (2004) and Walton (2007) by employing a more iterative, and theoretically-driven approach. I also referred to others (Berg, 2009; Jager & Maier, 2009; Keller, 2013; Mohammed, 2014; Polzer, 2006) who have successfully operationalized this approach in their own work.

I utilized a combination of analytic methods and strategies to interpret research data, including multiple layered readings (Eakin, 2015), coding (Benaquisto, 2008a; Saldana, 2016), analytic memoing (Groenewald, 2008; Saldana, 2016), and constant comparison (Hewitt-Taylor, 2001; Stern, 2008). I treated the data as two separate, yet complementary sets according to the method in which they were generated. This distinction is methodologically significant because each data set captures a different dimension of participants’ experience and, as such, has the potential to provide different insights about the phenomenon under study. Consequently, data analysis occurred in two stages, each following a distinct coding frame, or “guiding conceptual scheme” (Benaquisto, 2008b, p.89). The coding frames were developed both inductively and deductively, and were influenced by the type of data generated (interview vs. observation) as well as the specific research question. The remainder of this section details the specific focus and analytic strategies applied at each stage of data analysis.

4.1 Stage 1: Displays & Mapping

The first stage of data analysis focused exclusively on interview data. I began the analysis with multiple close readings of transcripts and field notes. The analytic objective at this stage was to better understand and reconstruct participants’ narratives of their overall migration journey rather than to conduct a detailed analysis of discourses. At this stage, I transformed the narratives into data displays, or visual formats, described by Miles and Huberman (1994) as a technique for both analysis and reporting of qualitative textual data. The specific format used in this study is that of networks, which are defined as “visual maps of [typically temporal or causal]
relationships...among individuals, events, social units, or properties of these” (Maxwell & Chmiel, 2014, p. 29). In order to construct these networks, I first created a critical incident chart (Miles & Huberman, 1994, p. 115) for each individual participant interviewed. Interview transcripts were coded inductively to identify all “critical incidents” relevant to the immigration process (including medical and non-medical CIC application procedures, the events and interactions that followed, and their effects insofar as they relate to the experience of TB screening and treatment, migration, and settlement), and listed chronologically. These charts served as a visual summary of participants’ narratives and facilitated comparative analysis, highlighting both commonalities and divergences of migration experiences across the study population. The 12 critical incident charts can be viewed in Appendix K.

Next, using constant comparison (Hewitt-Taylor, 2001; Stern, 2008), (an analytic method borrowed from grounded theory [Glaser & Strauss, 1967]), I iteratively constructed two composite event-state networks (Miles & Huberman, 1994) that represent the migratory pathways for two groups of applicants: those applying for immigration from within Canada (“In-Canada”), and those applying from another country (“Outside” Canada). The event-state network is a format that portrays events as well as the “consequences and/or antecedents of specific events” (Miles & Huberman, 1994, p. 115) (i.e. “states”); the events and states are connected by lines to better depict how and why events unfolded as they did throughout the process under study. These first version of the event-state networks were reviewed by my supervisory committee. Given that certain critical incidents (specifically some effects and facilitators encountered by participants) were unintentionally excluded, I conducted a second in-depth reading and more focused round of coding of interview transcripts, coding for actions, events, and material and social circumstances significant to the immigration and medical surveillance processes. This was achieved using a combination of descriptive and process coding (Seldana, 2016). The event-state networks were reviewed and revised to include any previously omitted data, and some additional details were added for completeness.

Lastly, upon deliberation with my supervisory committee, I consulted policy documents (CIC, public health, and clinical standards) to construct a third event-state network portraying the official version of the Migratory Pathway that conveys the expected sequence of events during the immigration process and TB screening. I incorporated the “official” Migratory Pathway into the participant-derived versions which allowed for a simultaneous portrayal of the emic and etic...
perspectives of the immigration and medical surveillance processes. These displays are presented in the first Results chapter along with analytic commentary.

4.2 Stage 2: Coding & Discourse Analysis

I began the second stage of data analysis with close readings of transcripts and field notes. At this stage, I included all data collected throughout the study. The analytic objective guiding my analysis was to understand how participants negotiated interpersonal encounters throughout their migration journeys. This stage of analysis was divided into two phases, one for each part of the second research question. For part A, which focused on interpersonal encounters pre-departure and post-arrival, I predominantly used interview data. To ensure relevance to the phenomenon of interest, I focused my analysis on encounters with health care professionals, clinicians, and public health workers. To answer the second part of the research question, part B, I relied on observational data collected at the TB clinic (appointments and field notes).

4.2.1 Coding

Dedoose, a web-based software, was used for management, coding, and analysis of all textual data (including transcripts, notes, and memos) generated over the course of the study. I began the analysis by coding all transcripts, field notes, and analytic memos. Codes were derived both inductively and deductively. I began with close readings and analytic memoing (Saldana, 2016). After completing close readings of all notes and transcripts and familiarizing myself with the data, I developed a list of Foucauldian concepts for coding based on emergent patterns observed in the data. While I used these concepts to guide coding, I focused on including other codes derived inductively from the data to ensure representation of participants’ perceptions and experiences (Hewitt-Taylor, 2001). I engaged in Eclectic Coding by combining four methods, as described by Saldana (2016): In Vivo Coding (using participants’ own words); Process Coding (using gerunds to “label actual or conceptual actions relayed by participants” [p. 77-78]); Concept Coding (analyzing data according to ideas or theoretically driven context relevant to the study); and Versus Coding (analyzing power relations by highlighting concepts, processes, phenomena etc. that are in direct conflict; codes are presented as ‘x vs. y’ [p. 137]) (see Appendix L). After coding all field notes, 8 transcripts of clinic appointments, and 4 interviews, no new codes were being added, indicating that theoretical saturation had been reached (Fusch & Ness, 2015; Guest et al., 2006).
Until this point, the analytic objective guiding my analysis was vague. Prior to coding, I set out to understand how participants negotiated power throughout their immigration journeys. Given that the analysis of ‘power’ (in a Foucauldian sense) can take many forms (i.e. by examining the discourses in operation, strategies of resistance, discursive practices, negotiation of subjectivities, etc.), this resulted in an unfocused analysis.

4.2.2 Locating Discourses

Because Foucauldian discourse analysis is both an iterative process and, arguably, should not have a set of prescriptive steps (Frost et al., 2010; Walton, 2007), it requires flexibility, creativity, and reflexivity (Fost et al., 2010) during analysis. My approach thus “defer[red] to a kind of interpretative activity” (Hook, 2001, p. 541) which, as Hook maintains, is “inevitable”. While coding, along with constant comparison, were both important techniques for making sense of the data, I found these approaches insufficient for a discourse analysis and, instead, supplemented extensively with analytic memos.

After returning to the theoretical literature and again comparing similarly coded segments across transcripts (Hewitt-Taylor, 2001), I derived at a reading (Stenner, 1993) of the data – that is, an informed explanation for the patterns revealed through coding. I consulted with my supervisor to narrow down an analytic focus, which was to examine how participants negotiated interpersonal encounters through strategies of resistance, compliance, and active participation. To provide a complete explanation of the power relations during these encounters, I examined the ways in which medical experts exercised power as well by the ways in which they enacted various discourses. This allowed me to shift focus away from what predominantly began as a textual analysis to one that focused more on the mechanisms of power/knowledge by not only attending to the effects of power, but also engaging with discourses as instruments of power (Hook, 2001, p. 539). With this new established and revised focus, I returned to the data to complete my analysis. At this phase, instead of coding, I read all transcripts once again. After indentifying relevant sections of texts, my analysis was guided by a set of analytic questions informed by Petersen and Lupton (1996):

1. What kind(s) of discourse(s)/practice(s) are invoked?
2. What are the underlying assumptions / logics of this discourse?
3. What view is privileged / silenced?

4. How is agency exercised? (i.e. resistance, active participation, compliance / docility, etc.)

5. How is the immigrant subject constructed / what subjectivities are produced?

6. What discursive strategies / tactics are used by experts?

7. What are the effects?

I maintained detailed analytic notes and interpretations of the emergent patterns observed in the data. I compared (Hewitt-Taylor, 2001; Stern, 2008) the results or this analysis between participants, which allowed me to highlight key sections of the encounters that were most salient to the phenomenon of interest. Constant comparison allowed me to group the emergent patterns of discourses, strategies of resistance, and subjectivities into dominant typologies. Furthermore, to add depth (Hook, 2001), the analysis of interpersonal encounters described here was situated within greater institutional discourses (immigration and public health policy, institutional guidelines for clinical practice) and their underlying logics to better understand the ways in which the intersection of immigration, public health, and medicine as discursive fields produced a network of power that informed the ‘conditions of possibility’ (Hook, 2001) at the micro-political level. These results, or my ‘reading’ of the data (Hook, 2001), were once again reviewed by my supervisor and the supervisory committee.

5 Ethical Considerations

This study required ethics approval from three separate institutions. Negotiating the bureaucratic processes of three separate REBs functioning under different and at times competing rationalities resulted in an extremely long and challenging ethics review process, much like what Davidow et al. (2009) reported. An in-depth analysis and discussion of these challenges are presented in Appendix D. Other ethical considerations that arose over the course of the study are described below.

5.1 Vulnerability & Risk to Participants

Both the topic of study and the population of interest characterize this research as sensitive, which potentially presents a greater risk of harm to participants. The participants in this study are
considered to be vulnerable on several accounts (Lahman et al., 2011; Flakerud & Winslow, 1998): they are all immigrants, many are ethnic and visible minorities, and many are women. As a group, ethnic and visible minorities, immigrants, and other newcomers often occupy a socially and economically marginalized location (Liampittong, 2007; Buchanan et al., 2002) in Western nations. Furthermore, all participants in this study were suspected of having TB and were undergoing testing and surveillance for this stigmatizing condition; their immigration status was perceived to be contingent on the results of these tests, making the IMS clinic encounter a high-stakes interaction. Consequently, these diverse subjectivities and interactions overlap as “intersecting marginalities” (Lahman, 2008, p. 282), collectively constituting research participants in this study as a vulnerable group.

According to criteria proposed by McCosker and colleagues (2001), several aspects of the phenomenon under study, as well as the methodological procedures employed (Lee & Renzetti, 1990), constituted this research as sensitive. First, the research topic (TB, IMS and immigration) is both private and stressful (McCosker et al., 2001) because it involves observation of the private medical encounter between the participant and the TB clinic staff and entails detailed conversations about the participant’s health in one-on-one interviews. Second, because TB is a highly stigmatizing condition, the very act of participating in the study can result in stigmatization if participants’ TB status is revealed to others in their family, community, or society. Consequently, the two greatest risks of harm to participants resulting from taking part in this study were psychosocial stress and the potential for discrimination and stigma. I address these issues below and discuss the precautionary measures that were taken over the course of this research to minimize these risks.

5.2 Privacy & Confidentiality

In most cases, participants would be at risk of experiencing discrimination and stigma if they were recognized in the study and identified as “TB patients”. A notable challenge faced by qualitative researchers is presenting and conveying the richness of the social world through participants’ accounts while simultaneously ensuring that the identities of those participants are protected (Kaiser, 2009). As such, my greatest ethical concern and responsibility as the researcher was to protect the identity of my participants. While collecting data anonymously was not possible due to the nature of the phenomenon under study, I relied on data alteration as a
strategy to protect the identities of my participants: I presented socio-demographic information in aggregate form simply to describe the population in this study as a group, I disguised various contextual identifying details about my participants (i.e. city names, states or countries of origin, past or current jobs, details about family etc.) in transcripts in an effort to prevent deductive disclosure (the ability to identify a person contextually through the details of their life stories [Kaiser, 2009]), I changed the dates and omitted some details about participants in the critical incident charts, and I instructed my participants to choose a pseudonym for the study. All possible steps were taken to ensure that participants’ private information was stored securely and remained anonymous in accordance with guidelines of all institutional REBs. This included ensuring that all individuals contracted to assist in the collection and analysis of data (e.g. interpreters, translators, and transcriptionist) signed confidentiality agreements (see Appendix M) and, when necessary, the transfer of electronic data was executed securely by encrypting and password protecting files.

5.3 Participant Representation in Research

An additional area of ethical consideration concerns the representation of study participants. Researchers engaging in studies with vulnerable populations must be cautious not to underestimate the consequences of the “choices [they] make about how to write about participants” (Liamputtong, 2007, p. 184); they must make deliberate decisions to represent respondents in ways that do not “other” and further marginalize them (Finley, 2005). A poststructuralist understanding of power allows me to recognize research participants as actively engaged in negotiating power throughout the immigration and IMS processes. This framing adopts the position that while study participants may be vulnerable in some ways, they are simultaneously capable and competent (Lahman et al., 2011). On the other hand, while anonymity may protect individual participants, writing about a highly stigmatized disease like TB in association with ethnicity, immigration status, or any other social location can potentially spark or fuel existent prejudices, bringing entire groups or communities into disrepute (Babacan & Babacan, 2013). Though there is no way to guarantee prevention of such negative consequences, a critical social perspective enables the researcher to take on an advocate position for vulnerable groups as a means to deter further social ostracism of research participants and the social groups which they identify with (Lahman et al., 2011).
5.4 Benefits of Participation

In qualitative research, in-depth interviews are a potential source of risk of psychosocial distress, yet they may also be perceived as beneficial to participants. Because in-depth interviews aim to generate data from private personal experience, they increase the risk of causing distress for the participants by forcing them to recount difficult situations (Bahn & Weatherill, 2013); conversely, however, talking about potentially stressful life events in the research context may provide therapeutic benefits for some (Eide & Kahn, 2008; McCosker et al., 2001). While several participants in this study experienced emotional distress and anxiety as a result of having to relive potentially painful experiences related to TB stigma or the immigration process, the benefit of catharsis seemed to outweigh this risk. After apologizing to Jane for eliciting distressing experiences during the interview which made her cry, she remarked: “No…it’s always good to talk about this ‘cause, I don’t talk about it as often here…it’s therapeutic so it’s good”. This sentiment was shared by other participants in the study. Moreover, many of my participants perceived the process of immigration and medical surveillance to be frustrating and lonely, and some viewed participation in the study as an opportunity to make a human connection. The research encounter provided a safe space where participants could share some of the personal struggles they were facing. Because there was always the potential for participants to require the assistance of a professional counselor, as a precaution I provided contact information for local crisis response programs on the consent form and instructed participants to utilize these if they felt they needed further emotional and physical support. To my knowledge none of the participants made use of this resource.

5.5 Compensation

The UofT REB instructs that research participants must be compensated for their time and participation in a study, but the value of these moneys should not be too high to present any undue influence (University of Toronto, 2011). All participants were offered $15 per interview, as well as reimbursement for public transit in the form of Toronto Transit Commission (TTC) tokens (or monetary equivalent) if they needed to travel to the interview location; most, however, were either reluctant to accept the money or refused it outright, stating that they were “not [taking part in the study] for the money”. Despite all assurances on my part, most still refused to
accept the honorarium. I felt that any further attempts to convince them otherwise would be unethical.

5.6 Consent as Process

As discussed earlier, participants recruited from the clinic provided written consent before taking part in observations and interviews; those recruited through the Public Health unit initially gave verbal consent over the telephone, then provided written consent prior to starting the interview.

I ensured that all participants read and understood the Information and Consent package, and urged them to ask questions before starting data collection. In this study, consent was ongoing and renegotiated not only at each subsequent meeting with the same participant, but also throughout each interview. Ongoing consent requires an open dialogue for negotiating, reflecting on, and discussing the boundaries set by each participant at multiple points during the study (Duncombe & Jessop, 2012). I achieved this by: 1) informing all of my participants of their right to withdraw from the research at any point in time; 2) explicitly conveying that they are not under obligation to answer any question if they choose not to; 3) permitting them to speak off record at their discretion; and 4) by checking-in to clarify whether they wanted to elaborate off record if I sensed a subtext, non-verbal cues, or hesitation in their response. My goal in enacting these strategies was to encourage my participants to freely express themselves within the boundaries of what they considered to be acceptable. While a few participants requested to discuss private matters off record and declined answering some questions on the Socio-Demographic Questionnaire, none withdrew from the study after initial consent was given.

6 Study Limitations

In this section, I highlight the most significant limitations of the study and consider the extent to which the findings of this research are transferable to other contexts. The contributions of this study are discussed in detail in the following chapters.

The first limitation is that the study sample is not representative of all groups of immigrants, particularly those who typically undergo TB IMS. Although the group of participants in this study was heterogeneous in terms of age, gender, ethnicity, country of origin, and immigration class, most were well educated, spoke English, and emigrated from high- and middle-income
countries. The study participants represent a more socioeconomically affluent group of newcomers to Canada, which carries significant considerations for the study. Namely, privilege afforded by the social locations described above not only improves access to social and material resources, but also endows these individuals with a greater ability to negotiate power in social and institutional encounters throughout the immigration and IMS processes in ways that facilitate self advocacy.

Second, although my study sample included immigrants from various classes such as international students, one refugee, and one temporary foreign worker, my primary focus was on permanent resident applicants. As such, refugees and temporary workers as a group were not adequately represented in the data. Furthermore, this study was not designed to access immigration applicants who fell out of status (regardless of whether they remained in Canada as undocumented migrants or were forced to leave the country), and their collective experiences could not be included here either. Against the backdrop that considers the complexity of global migration patterns, while I aimed to capture a range of migration experiences to understand how immigration medical surveillance affects newcomers, these findings represent only a fraction of migratory trajectories, restricting the transferability of the results to very specific groups of immigrants.

Third, while I aimed to capture the experience of undergoing immigration medical surveillance for individuals in all diagnostic categories (e.g. active TB, LTBI [accepted and rejected prophylaxis], and no TB), none of my participants were diagnosed with, or had to undergo treatment for active TB as a consequence of immigration medical surveillance at the time of their interview. This is worthy to note considering the consequences that an active TB diagnosis carries for immigration applicants: Unlike LTBI, treatment for active TB is mandatory under the Public Health Act for all Canadians and, in the case of immigration applicants, CIC clearance is only granted after proof of treatment completion has been received. Therefore the social challenges associated with TB disease and its treatment (i.e. physical isolation, frequent clinic visits, etc.) presumably exacerbate the difficulties already present during the settlement period for newcomers and their families. It would be logical to assume that under these conditions, the options of permissible conduct available to “immigrant applicants / patients” is much different for those with active TB versus LTBI or no TB as the options for the latter two are not mandated by law. By restricting their negotiating potential, the lack of choice that comes with an active TB
diagnosis would exacerbate power imbalances inherent in social and institutional relationships; it would affect the degree with which immigration applicants with active TB can negotiate their positionality during social interactions with various actors encountered throughout the medical, public health, and immigration systems. Nevertheless, while the unique views and experiences of newcomers with active TB were not captured in the data and could not be represented in this work, some of the findings from this study can still be transferable to this group of migrants if one considers that completion of, and compliance with, medical surveillance is mandatory for all immigrants suspected of having active TB or LTBI, irrespective of clinical findings.

The study recruitment site presented a fourth limitation to the research as the choice of location for participant recruitment had a significant impact on who was included in, and effectively excluded from, the study. Although the clinic is the busiest in Toronto and services an ethnically diverse clientele, the patients who present there are constrained by the catchment area of the hospital. As such, the pool of prospective IMS candidates available for this study is likely not socio-demographically representative of immigrant populations assessed at any other TB clinics in Toronto, or elsewhere in Canada. Furthermore, because Public Health authorities typically refer newcomers to family physicians or walk-in clinics for their IMS assessments, the participants in this study do not represent what would be considered the “typical clinical experience”. Due to low incidence of TB in Canada, there is significant variation in the degree of experience diagnosing and treating TB among family physicians (Ontario Lung Association, 2015); thus the experience of patients completing medical surveillance in the context of family practice would be drastically different from those described here. Having said that, several participants in this study initially consulted or were assessed in a primary care setting, therefore these perspectives are not completely absent from the data.

7 Research Quality

As a Foucauldian discourse analysis, the approach employed in this study can be labeled both constructivist and critical: It assumes that the view of the world as well as the knowledge produced within and about it is socially and politically constructed; it seeks to examine multiple perspectives and realities of the world; it aims to make visible the ways in which power is negotiated and operationalized by marginalized groups; and it represents the views and experiences of the ‘less powerful’ (Patton, 2002b). Patton (2002b) lists a number of sets of
criteria specific to these frameworks upon which the integrity of the research process can be assessed, most notable of these being trustworthiness.

Lincoln and Guba (1985) developed the concept of ‘trustworthiness’ as criteria used to establish scientific rigour of naturalistic inquiry. The authors formulated the notions of credibility, transferability, dependability and confirmability as analogues for criteria conventionally used to assess rigour of quantitative studies (e.g. internal validity, generalizability, reliability, and objectivity, respectively). Building on Lincoln and Guba’s (1985) original argument, Cheek (2004) challenges the positivist criteria of quality assessment on methodological grounds from a discourse analysis perspective, pointing out that the concepts of validity, generalizability, reliability and objectivity are discursive constructions in and of themselves. She emphasizes that discourse analysis is not concerned with the data itself, but rather with the meanings and contexts under which data came to be in the first place. Thus the question is not ‘how reliable / valid / generalizable are the data?’ but rather ‘how were the data constructed / produced in a particular context?’.

While there is no way of guaranteeing that a study is completely “balanced” and “compelling”, the techniques used to satisfy the criteria outlined by Lincoln and Guba “provide a system of useful checks and balances” (Lincoln & Guba, 1985, p. 108). Thus trustworthiness, in short, is a way of ensuring that the study findings are persuasive enough to be meaningful in a way that does not confine the qualitative investigator to the parameters of quantitative research. I have chosen to focus the remainder of this discussion on three trustworthiness techniques employed during the course of this study: triangulation, audit trail as a means for transparency, and reflexivity.

7.1 Triangulation

Triangulation is seen as a way of adding credibility to qualitative research findings as it helps to compensate for the limitations of any single method of data collection or analysis (Denzin, 1970; Lincoln & Guba, 1985; Jensen, 2008; Rothbauer, 2008). As no one method of data collection is ‘perfect’, by combining two or more approaches the investigator “can achieve the best of each, while overcoming their unique deficiencies” (Denzin, 1970, p. 308). The benefits afforded by methodological triangulation include the ability to “capture and report multiple perspectives rather than a singular truth” (Patton, 2002b, p. 267). In this study, the ability to observe the clinic appointments allowed for a first-hand account of the ways in which newcomers undergoing TB
surveillance negotiated the medical encounter, enabling me to examine how they take up and operationalize discourses to position themselves in relation to the clinicians. But because the clinical encounter is just a small part of the IMS and immigration and settlement processes, it provided a very fragmented understanding of immigrants’ experiences; this method of data collection is restricted in time and space to the observed situation and says little about what occurred before it, or what the person being observed thinks or feels (Patton, 2002a).

Other limitations of this method include observer reactivity (Denzin, 1970) and the researcher’s “selective perception” of the encounter (Patton, 2002a, p. 306). Through triangulation of data sources (Rothbauer, 2008), I combined observational data with data generated through interviews; this permitted me to not only incorporate my respondents’ own perspectives about surveillance and immigration, but also enabled me to situate the clinical encounter in a wider context, regarding it as just one example of the many ways in which newcomers negotiate power. Such convergence of data allowed me to address different aspects of a single research problem (Rothbauer, 2008), providing a more complete understanding of the phenomenon under study.

7.2 Transparency & the Audit Trail

Qualitative inquiry requires a certain degree of flexibility in its design as the processes of data collection and analysis develop and change over the course of the study through an iterative process. As a result, it becomes important to keep a record or a “trail of evidence” (Rodgers, 2008, p. 44) of all the amendments to the research design, as well as “notes about data collection experiences…the researcher’s experience in the conduct of the study, and memos generated during data analysis” (Rodgers, 2008, p. 44). Transparency is of particular importance when the intended audience may not be familiar with the research design or theoretical or analytical frameworks employed (Green & Thorogood, 2009, p. 220), as is the case in this study. Furthermore, maintaining an audit trail achieves two important goals: first, by explicitly providing a clear account of the steps taken to generate and analyze data, it enables others who may wish to replicate the study to do so; and second, if done correctly, it allows the reader to judge for themselves whether the methods used were appropriate for the aims of the study (Saumure & Given, 2008, p. 796). In this fashion “[t]he audit trail provides a mechanism for retroactive assessment of the conduct of inquiry and a means to address issues related to the rigor of the research as well as the trustworthiness of the results” (Rodgers, 2008, p. 44). Meticulous
record keeping and the presentation of the various steps taken over the course of the study thus ensures that the investigator remains accountable for their actions at each phase of the research process.

I took several steps to maintain an audit trail throughout the course of my research. I recorded detailed field notes after all clinic observations and interviews to document the context under which each encounter took place; these notes also included reflexive memos about my experience as a researcher and as co-creator of data. Any challenges or potential problems experienced in the field with respect to participant recruitment or data collection were also noted. These issues were discussed on an ongoing basis with my supervisory committee, and the minutes of the meetings, particularly those documenting methodological decisions, were also included as part of the audit trail. In the reporting of this study I sought to demonstrate the integrity in which the study was conducted (through design and method), in the analytical procedures, and of the findings themselves. First, I provided detailed accounts of the methodological steps taken during the research process, as presented in this chapter. Second, analytic transparency was sought by maintaining an audit trail of the procedures and strategies employed to analyze data, as well as by keeping a reflexive journal to help document the cognitive process involved during this phase (Rodgers, 2008). Earlier in this chapter I described the evolution of codes and themes as they developed over time, supplementing this information with relevant insights. Third, and last, transparency of findings in discourse analysis is best achieved by supporting analytic claims with “extensive use of the actual textual material…for it allows others to assess the researcher’s interpretations and follow the reasoning process from data to conclusion” (Lupton, 1992, p. 148). As such, the findings and assertions I make in the following chapters are heavily supplemented with actual text generated through observations and interviews.

7.3 Reflexivity

Reflexivity is not just an effective strategy for rigour, but is rather “fundamental to successful qualitative research” (Crabtree & Miller, 1999, p. xvi). In naturalistic inquiry, reflexivity is used to account for the presence and influence of the investigator over the entire research process. The pursuit of rigour compels the researcher to continually engage in a process of reflexivity (e.g. “critical self-awareness”) and reflection (e.g. “thinking about something”) in order to assess and
report on the ways in which her role as the primary research instrument has influenced the results of the study (Holloway & Brown, 2012; Finlay, 2011; McCabe & Holmes, 2009; Dowling, 2008; Saumure & Given, 2008).

The two most common types of reflexivity used in qualitative studies, and the two that are relevant here, are ‘personal reflexivity’ and ‘epistemological reflexivity’ (Holloway & Brown, 2012; Willig, 2008; Dowling, 2008). Personal reflexivity addresses the ways in which the researcher’s identity and assumptions stemming from their beliefs, values and interests and experiences shape the study. It also involves reflecting on the ways in which the researcher, both as a person and investigator, has been shaped by the research process (Willig, 2008). Epistemological reflexivity, on the other hand, takes a more broad approach, referring to the research endeavour as a form of knowledge production. This approach questions the researcher’s involvement in the research process by addressing the assumptions upon which the research question and the methods of data collection and analysis were based. Because the methods employed in a study are not neutral techniques and “carry the epistemological, ontological and theoretical assumptions of the researchers who develop them” (Mauthner & Doucet, 2003, p. 415), epistemological reflexivity forces the investigator to reflect on the ways in which these factors shaped the understanding of the phenomenon under study and what implications this has for the findings (Willig, 2008).

In both approaches, the notion of reflexivity acknowledges the researcher as a socially situated and subjected actor embedded in a historical, political, social and institutional context. Same as any other, the researcher as “poststructural self” (Fine, 1994) has multiple subjectivities and simultaneously occupies various social locations. When engaging in poststructural research, the investigator must account for the ways in which these aspects of the self intersected with, and in relation to, that of the participants’ in order to interpret the data in a meaningful way. By making privilege, contradictions and context explicit, reflexivity erodes the researcher’s authority (Fine, 1994) and promotes a focus on the role of power as it relates to knowledge production through the research process. My use of reflexivity in helping to maintain an audit trail was already discussed above. In this section, I outline the ways in which I used reflexivity at different phases of the research process as a means to promote authenticity and trustworthiness of the study (Patton, 2002b; Lincoln & Guba, 1985).
7.3.1 Using Reflexivity in this Study

As the researcher and “primary research instrument”, I used reflexivity to expose how I may have influenced the data generated in this study (Saumure & Given, 2008). I reflected on the research encounters through a poststructuralist lens in an effort to better understand the methodological significance of my subjectivity and positionality. Before the study began, I believed that my subjectivity as an immigrant adequately prepared me to study other immigrants’ experiences as I felt that through my own migration journey I was somehow bestowed with an insider perspective and ‘group membership’. As the study progressed, however, I was both surprised and confused by the varying degrees of relevance that this positionality had on different research encounters: while sometimes I drew on my subjectivity as an immigrant to probe further about a certain issue (e.g. “I remember what it was like coming to Canada, but I was a child. What was that like as an adult?”), at other times I completely abandoned this positionality in favour of another (i.e. mother, student, etc.). As my positionality became complicated through relational interactions with my participants (Choi, 2006), my subjectivity as an immigrant, and any claim to ‘insider experience’ as such, no longer held the primacy I had expected.

Upon my reflection on the interviews, it became clear that the ways in which I positioned myself in these encounters shaped the direction of the interview conversation (Choi, 2006), and therefore affected the type of data that was generated. For instance, when Michael disclosed the negative consequences of immigration on his marriage and family, I recognized the very same struggle and hardship from my own immigration experience as a child. While I acknowledged this and briefly disclosed this to Michael, I had to fight my natural inclination to become more involved in the conversation because, in that moment, my primary purpose was to generate data with him. As such, while I interpreted the information from my social location as an ‘immigrant’, I had to consciously and deliberately suppress my further involvement in the conversation and respond from my positionality as a ‘researcher’.

Reflecting on this example, I became aware of a few things. First, while my social locations (i.e. white, middle-class, heterosexual woman) never changed over the course of the study, I realized how often I shifted and blurred the boundaries between my various subjectivities, highlighting the relational and situational nature of positionality (Choi, 2006). For instance, my identity as
‘immigrant’ was always questioned and indirectly challenged by my participants because of my race, education and English fluency (including lack of an accent). In order to legitimize any claim to insider status I had to negotiate this positionality, which was often achieved by disclosing my migration history as well as the source of my privileged location as an immigrant (i.e. immigrating from Europe, living in Canada for over 20 years, etc.). Second, as a student and first time qualitative researcher, I struggled with my new emerging position of ‘researcher’ and constantly questioned the degree to which I should be involved in the interviews. To elaborate, whenever my participants made statements about TB that were medically inaccurate, I had to refrain from ‘correcting’ them: While on the one hand I felt that providing them with medically accurate information might be helpful in their situations and was ‘the right thing to do’, I knew that intervening in this way would be detrimental to the purpose of the study as it would interfere with my ability to learn about their own perceptions and understanding of TB. (I did, however, offer the biomedically accurate information at the end of our encounter). In a way, I became preoccupied with the positivist notion of objectivity and bias, constantly worrying that I would be ‘tainting’ the interview data with my own perspectives. On the other hand, however, given that my participants at times explored deeply personal and emotional issues throughout the interview process not directly relevant to the study, I often listened and responded genuinely and with empathy as a friend rather than a researcher. Through this exercise, I became more aware of the ways in which my positionality and subjectivity affected not only my interpretation of the data, but also my involvement in shaping the text.

In an effort to promote reflexivity, I had to review how I, as a researcher, am situated within the discourses that I am studying, which discourses I deployed throughout the research process, and for what purpose. I spent most of my ‘academic upbringing’ embedded in the positivist paradigm: It was not until I began my graduate studies that I was introduced to critical social perspectives on health, the body, and society. Although this research (including the theoretical perspective used, the research questions asked, the methodology and research methods chosen) reflects my deliberate intent to study these intangible forces that are ‘discourses’, and is driven by my desire to, at least in some small way, improve the situation of those disparaged by them, I have come to realize and acknowledge that I am operationalizing these discourses myself and, as such, am complicit in reproducing these power relations and the social structures which they uphold.
It has been a constant struggle for me during data generation and in the writing of this thesis to reject drawing upon, and ascribing to, dominant medical and epidemiological discourses around TB and immigration in favour of more critical views. This became apparent at the beginning of the study when some members of my supervisory committee pointed out in earlier drafts of my dissertation that my writing was “too positivistic” and that I must adopt a “more critical lens” and language. While I tried to compensate for this through revisions and a more critical self-awareness during the writing process, in retrospect I realized that my positivist background influenced the interview process as well. For instance, while I was interested in understanding how my participants conceptualize TB, I was hyper aware of how medically inaccurate some of their answers were and, in response, would probe for further explanations. In effect, by assessing my participants’ degree of health literacy I was implicitly making judgments about how ‘ignorant’ they were (in relation to medical discourse as the dominant form of ‘truth’). I was, and still am, uncomfortable with the implications of my own assumptions and discursive practices on my participants. As a social health researcher, I am constantly struggling morally with my own location within these discourses: On the one hand, I value scientific (particularly biomedical) knowledge and ascribe to it completely - I accept that I must do this in order to function effectively as a health researcher; on the other hand, however, it feels hypocritical to take up these very same discourses and forms of knowledge that I aim to problematize, particularly because of the social structures that these discourses reproduce and the inherent privilege that comes with being the speaker of these discourses.

As a researcher using a critical perspective, confronting my own privilege has been both challenging and frightening, though necessary. Fine (1994) makes a point about researchers working from these perspectives having to barter “privilege for justice” in order to give voice to “subjugated Others” (p. 79). If it was not for their privileged position (afforded to them through race, class, education, sexuality, etc) they would not be able to act as “translators” for their participants, and their experiences would probably not be heard at all. Jane’s migration journey demonstrates this point. Because her immigration application expired in part due to delays caused by the medical surveillance process, she “fell out of status” and had to return to her country of origin. Jane explained that while she appealed for help to her local Member of Parliament, her case was dismissed by CIC on the grounds that her situation was “not uncommon”. The fact that this type of situation – where people’s lives are completely disrupted
as a result of bureaucratic errors – is constructed as ‘typical’ and ‘common’ and consequently ignored by the government, is incredibly troubling to me. Furthermore, because the voices of newcomers undergoing medical surveillance are muted in the political arena, it legitimizes my role as someone who could provide a “scholarly translation” (Fine, 1994, p. 80) to those whose stories would otherwise be ignored. While the intent may be noble, this position presents a contradiction for critical social researchers: Because “the class politics of translation demands that a researcher is doused quite evidently in status and privilege”, the researcher’s role as translator thus “colludes in structures of domination” (Fine, 1994, p. 80). A similar point is made by Cheek (2004) in relation to the method of analysis used in this study: While the goal of discourse analysis is to uncover the implicit power relations and identify the conditions under which some gain legitimacy as experts, the very process of conducting discourse analysis privileges the voice of the researcher as an expert, thus legitimizing their own discourse and interpretation over that of the participants. Reflecting on these issues has shaped my relationship to the data and influenced my interpretations and (re)presentation of the findings. Being cognizant of these arguments has helped me to develop a better understanding about my own discursive formation and my power as a researcher in this study.

8 Chapter Summary

I opened this chapter by outlining the methodology employed in this study and demonstrated both its congruence with the theoretical perspective as well as its appropriateness for investigating the phenomenon under study. I provided a rich account of the ways in which the research process evolved, highlighting those changes in the procedures and design of the study with greatest methodological implications for the data generated. I described the analytical procedures followed and applied to the research text, presenting the evolution of codes and analytic themes. Following a discussion on topics of ethical concern, I called attention to the limitations of this work and described the context in which the study findings are transferable. Lastly, I discussed my use of triangulation, maintaining an audit trail, and use of reflexivity throughout the research process as a means of enhancing the quality and rigour of the study.

In the following three chapters I present the results of the analysis. Each chapter is dedicated to answering one research question pertaining to the phenomenon of interest.
Chapter 5
Results I: Migratory Pathways

“This story begins before you arrive, and it will end after you are gone. Perhaps it begins even before I start to tell it…”

(Rosnau, 2002, n.p.)

1 Introduction

The results presented in this thesis reflect the analysis of data at two levels. In this first Results Chapter, the analytic gaze is directed towards the system. Specifically, I provide a descriptive account of the processes and systems, their articulation, and their effects particularly as they construct the social and material reality of immigrants, thus defining and shaping the condition of possibility. In the next two chapters, the analytic gaze is directed towards interpersonal encounters. While those results are directed at the micro-political level to depict the ways in which these encounters are negotiated through the exercise of power, they are situated within the context of the immigration and medical surveillance processes. The results presented in this chapter are intended to answer the first research question, which asks:

*How are immigrants governed through intersecting Canadian policies on immigration and public health during the immigration and settlement process, both in-Canada and abroad?*

Screening and surveillance for TB among newcomers is situated in a larger context of immigration and settlement. In order to understand how immigrants would experience that specific aspect of the immigration and settlement process, it is necessary to consider their journeys in their entirety. To do this, I synthesized participants’ interview data and constructed a visual representation of participants’ collective Migratory Pathways as two “maps”. These pathways depict the necessary steps taken to undergo and complete TB screening and surveillance before, during, and after immigration, and the chain of events initiated by and encompassed within this process. These maps enable the reader to visualize the participants’ progression *through* the immigration processes, and help situate the analysis of discourses within
each participant’s narrative. While this process involves many social actors, the pathways presented here were constructed using participants’ accounts and represent their perspectives and personal experiences (emic account). These pathways are representative of the way in which the immigration and settlement process (as well as immigration medical surveillance [IMS] and immigration health screening) is structured in Canada. In addition to presenting the Migratory Pathways, I have included a chronological narrative which draws on the experiences and first-hand accounts of study participants to help explain what this process entails.

2 Understanding the Structure of the Immigration Process

Immigration is a highly structured bureaucratic and selective process. Each hopeful candidate must first determine whether they meet specific eligibility criteria to be considered for immigration by the Canadian government. Those who qualify must then compile an Immigration Application Package in accordance with the policies and procedures outlined by CIC. Thus an applicant’s success, which is marked by obtaining approval for temporary or permanent residency, is not only dependent upon the information contained within the application package, but also rests in part with the candidate’s ability to complete the application package itself as per directions.

Given that an individual’s physical and mental health status is an essential criterion for admissibility, the medical exam features as a crucial component of the immigration application. As such, health-based policies and practices are directly incorporated into the immigration process; these policies not only determine the type of information that CIC deems relevant about an applicant, but also inform the ways in which this information can be collected, and by whom (namely, physicians). Therefore the policies and professional standards guiding conduct and practices of medical and public health officials, both within Canada and abroad, inform and intersect with the legislative framework of the Canadian government to structure the immigration application process, ultimately shaping the applicant’s overall journey to becoming Canadian immigrants.
3 Migratory Pathways

I have constructed three Migratory Pathway maps. The first (Figure 5.1) illustrates the official policy version as outlined by CIC, which largely incorporates the immigration application process. This pathway was derived using official policy documents, guidelines and procedures mandated by CIC in accordance with Public Health Agency of Canada and standard clinical and public health practices around TB screening, treatment and control in Canada overall, and Toronto specifically (CIC 2013c, 2014a,b, 2016a; IRCC 2016a,b; Ontario Ministry of Health and Long-Term Care [OMHLTC], 2008; PHAC, 2014a; Toronto Public Health, 2017a,b). It is important to note that the information presented in these figures is relevant only for TB screening and does not take into account any other medical conditions of interest to CIC. The pathways depicted in Figures 5.2 and 5.3 were derived directly from interview data with participants and represent their perspectives and experiences of the process. Despite the diversity in experiences and migration trajectories among study participants, two main pathways emerged in accordance with the location where the immigration application was filed (either from within or outside Canada). This distinction arose due to differences in participants’ experiences of the medical examination and subsequent referral for follow-up and medical surveillance in Canada versus other countries. As such, Migratory Pathways are categorized as either “Overseas” (for temporary resident (TR) or permanent resident (PR) applications [Figure 5.2]) or “In-Canada” (for PR applications only [Figure 5.3]).

The presentation of the policy-derived (i.e. the “official” version) and data-derived (i.e. the participants’ version) Migratory Pathways together is important because it allows for the appraisal of the immigration process itself. Given that policies and procedures surrounding the immigration application process set up parameters for the ways in which applicants (as well as others actors involved in the process) can act, a close examination of the policy helps to contextualize the experience of applicants as they move through the immigration process. The degree with which official and participant versions of the Migratory Pathway converge or differ demonstrates how well the policy translates to real life; listening to the experiences of the applicants has the potential to uncover the effects of this policy on the social and material reality of those individuals.
3.1 Social Actors & Their Involvement in the Immigration Process

There are several key actors involved in the immigration and medical surveillance processes. Aside from participants who are both immigration applicants and immigrants/newcomers depending on what stage in the Migratory Pathway they are completing (pre-departure or prior to approval of the CIC application they are ‘applicants’, while after the approval of their CIC application and upon arrival in Canada they become ‘newcomers’ or ‘immigrants’), this process also involves various experts, officials and authorities. Participants’ identities (subjectivities) are relational to these authority figures and depend on who these social actors are and what function they serve in this process. While I describe these relationships in detail in the next chapter, I outline them here to assist with the reading of the Migratory Pathways.

For CIC authorities (CIC agents, border agents, and other administrative government staff), the individuals applying for immigration to Canada are ‘applicants’. One of the sources of frustration for participants during this process was their confusion over the perceived roles of each social actor encountered during the Migratory Pathway. As a result, applicants do not know which expert / authority figure is following which mandate – whether they are functioning in their role on behalf of CIC or the applicant. As I will go on to show in the results and discussion, this uncertainty has eroded the trust that applicants have towards various medical and public health experts.

Panel Physicians (PPs) and other Panel Members (PMs) are physicians and other clinical staff (such as administrative clinic staff, medical technicians, nurses, etc.). While these medical experts include health care providers, their role is to conduct a medical assessment of the individual as a CIC applicant on behalf of the Canadian government rather than for the individual as a patient. Because these doctors are authorized to provide a service for the Canadian government as third-party physicians (Elien-Massenat, Medical Advisor IRCC, personal communication, August 2017), in relation to the individual undergoing the application process, PPs operate as medical ‘border agents’. As such, contrary to the typical doctor-patient relationship, their relationship is defined by CIC (2016a) as transactional, where applicants become PPs’ ‘clients’. Similarly, Regional Medical Officers (RMOs) are medical health experts,
but their role in this process is strictly administrative as they do not directly interact with applicants.

In contrast to PPs, other medical experts such as TB specialists and clinicians (i.e. pulmonologists/respirologists, nursing staff, respiratory therapists, TB clinic administrative staff etc.), as well as public health staff, maintain their traditional relationship with applicants (individuals remain patients and ‘public health clients’ – a technical term used by Canadian public health nurses outside context of immigration). Despite their function in medically assessing applicants and newcomers for TB and reporting these results to CIC/IRCC, these experts are not officially incorporated into the immigration application process. They remain in their respective disciplinary institutions and function primarily in their role as health care providers and public health officials. As such, however, TB clinicians are unclear about what specific documentation is needed from them as part of the CIC application for their patient, or what the exact procedures are in completing the TB furtherance process (described in detail later in this chapter) in which they are involved. Despite their desire to help their patients, as I go on to show in the Results Chapters, TB clinicians are also constrained by CIC policies.

4 Migratory Pathways: Participants’ Experiences

This section details the journey of applicants along the Migratory Pathway. It highlights all the steps of the Immigration Application Process relevant to this study, starting with the initiation of the application process and ending with obtaining complete CIC approval and secure immigration status (which occurs after all conditions of medical surveillance have been met), following the sequence depicted in Figure 5.1. At each step, I begin by presenting the official policy version (in blue, coloured boxes), outlining the necessary requirements and procedures that the applicant and officials involved must meet in order to move to the next step. To demonstrate the contrast between policy and the lived reality of users, these descriptions are followed by participants’ own accounts and experiences (in red and orange), which are punctuated by barriers (red) and facilitators (green) to the completion of each step, as well as some of their effects. To emphasize and translate some of the frustrations participants experienced during this process, I have kept the original emphasis in their speech (this is represented in italics within participants’ quoted remarks throughout). Any deviations from the official Migratory Pathway are depicted in Figures 5.2 and 5.3.
Figure 5.1  Migratory Pathway: Official Policy Version

Step 1: Compiling the CIC Application

INITIATE APPLICATION PROCESS
Begin compiling application package

Step 2: Immigration Medical Exam (IME)

Upfront Medical Exam?  NO

YES

2A: Conducting the IME

Immigration Medical Exam (IME)
Performed by Panel Physician (PP)

Follow-up Required?  (Abnormal chest x-ray and/or history of TB)

YES

Follow-up Appointment with PP
IME Results submitted to CIC’s Regional Medical Officer (RMO)

Further assessment required?  (Results suggestive of active TB etc.)

YES

Referral for TB Furtherance

2B: TB Furtherance

Complete treatment for active TB  (~6 to 9 months)

YES

TB Specialist Assessment (IME)
chest x-ray, sputum collection

Active TB?

YES

Follow-up with TB specialist required?

NO

2C: IME Medical Clearance

TB Furtherance & IME Completed
Report submitted from TB specialist to PP
PP forwards complete report to CIC’s RMO

Submit Complete Application to CIC

IME still outstanding?  NO

TIME LINES

N/A

Few days to ~ 11 months

Processing Time
Few weeks to ~ 26 months

ABBREVIATIONS: IME: Immigration Medical Exam; IMS: Immigration Medical Surveillance; OHIP: Ontario Health Insurance Plan; PP: Panel Physician; RMO: Regional Medical Officer
Figure 5.1 (continued)

Step 4: Application Approval

Step 5: Arrival in Canada

Step 6: IMS

6A: Contacting Public Health

Approval of Application by CIC
Referral for post-arrival immigration medical surveillance (IMS)

ARRIVAL IN CANADA / PR LANDING
Instructed by border agents to contact Public Health for IMS (Med. Surv. Handout)

Contacting Public Health Authorities

Complex inactive TB or suspected active TB?

YES

NO

Referral to Primary Care
(family physician or walk-in) for medical assessment
wait until OHIP received ≥3 months

Initial IMS Medical Assessment
Performed by primary care physician
(incl. chest x-ray)
Results submitted to Public Health

Further investigation required?

YES

NO

Referral to TB Specialist

6B: IMS Medical Assessment in Primary Care

6C: IMS Medical Assessment with TB Specialist

Complete treatment for active TB
+ ~6 to 9 months

YES

Active TB?

NO

Follow-up with TB specialist required?

YES

NO

TB Specialist Assessment (IMS)
chest x-ray; sputum collection

6D: IMS Medical Clearance

IMS Completed
Results submitted to Public Health
IMS discharge letter mailed to client

Submit Proof of compliance with IMS to CIC

THE END

N/A

0 to 30 days

~ 0 to 90 days

N/A

2 to 9 months +

N/A
Figure 5.2  Migratory Pathway: “Overseas” CIC Applicants

ABBREVIATIONS: IME: Immigration Medical Exam; IMS: Immigration Medical Surveillance; OHIP: Ontario Health Insurance Plan; PP: Panel Physician; RMO: Regional Medical Officer; TB-UP: Treatment Services for Uninsured Person Program
Figure 5.2 (continued)
Figure 5.2 (continued)

PRE-DEPARTURE

Higher cost of airfare if must arrive in Canada by specific date + $  

Denied entry to Canada + days to months / + $  

Visit government offices / immigration service centres in search of assistance + days to months / + $ / psych. stress

Processing errors / delays + weeks-years

Have any parts of the application package expired (excluding IME certificate)?

Has the IME certificate expired?

Step 4

Approval of Application by CIC
Referral for post-arrival immigration medical surveillance (IMS)

Insufficient information about IMS process after arrival
Fear / anxiety / psychosocial stress

Family living in Canada learn about IMS process before applicant’s arrival

Step 5: ARRIVAL IN CANADA

Missing any documentation necessary for entry into Canada?

Instructed by border agents to contact Public Health for IMS (Med. Surv. Handout)

Insufficient information about IMS process
Fear / anxiety / psychosocial stress

Are instructions to comply with IMS understood?

Step 6A

YES

Contacting Public Health Authorities

Complex inactive TB or suspected active TB?

YES

Visit primary care phys.; undergo med. assessment + days to weeks / + $ (no OHIP)

Visit community health clinic (familiar w/ IMS); Free health care for uninsured save $  

Correct info obtained?

NO

2 months to few yrs

4 months to ~5 yrs

5 days to 3 months

0 to 30 days

5 months to >2.5 yrs
Figure 5.3  Migratory Pathway: “In-Canada” CIC Applicants

INITIATE APPLICATION PROCESS
Begin compiling application package

Correct application forms obtained / completed?

Yes

Upfront Medical Exam?

No

Yes

Insufficient Instructions / directions; incorrect information from CIC

Help & support from family / friends less stress

Insufficient Instructions / direction
Wait times for appointment + days to months
Travel to clinic + time / + $

Immigration Medical Exam (IME)
Performed by Panel Physician (PP)

Insufficient Instructions; Policy-driven / client’s concerns not addressed

Follow-up Required?
(Abnormal chest x-ray and/or history of TB)

Follow-up Appointment with PP
IME Results submitted to CIC’s Regional Medical Officer (RMO)

Further assessment required?
(Results suggestive of active TB etc.)

Simultaneously undergoing IMS for TR application process?

Yes

PP obtains IMS medical files
no TB Furtherance
save $ / save time
(2 months) / less stress

No

YES

NO

~ 2 to 3 months

min. ~4 to 6 months (still ongoing)

2 to 14 months

Step 1

Step 2A

ABBR EVIATIONS: IME: Immigration Medical Exam; IMS: Immigration Medical Surveillance; OHIP: Ontario Health Insurance Plan; PP: Panel Physician; RMO: Regional Medical Officer; TB-UP: Treatment Services for Uninsured Person Program

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Figure 5.3 (continued)
Figure 5.3 (continued)
Despite a series of prescribed sequential steps inherent to the immigration process (as illustrated in the present study), it is important to emphasize that neither the application process, nor immigration itself, are perfectly linear. While my aim is to present the results as coherently and clearly as possible, a significant degree of overlap exists between the two pathways where some stages run concurrently, particularly during the post-arrival phase. Although this could not be depicted in the pathways, I explain when this occurs in the accompanied descriptions.

4.1 Step 1: Compiling the CIC Application

Individuals interested in immigrating to Canada must first ascertain whether they are eligible to do so and which immigration program they qualify for. In addition to completing the application form, candidates must compile their application package; packages may include documents and forms such as a police certificate, marriage certificate, passport information, photographs, letters from individuals / institutions (for work or study), financial information, medical information, and any documents required for the assessment of the sponsor (for sponsorships). The exact documents required are specific to each immigration program. Additionally, applicants must not only pay a processing fee, but are also responsible for covering the cost of any required documentation included as part of the application package.

4.1.1 Barriers

The first challenge described by participants at this initial stage of the immigration process was identifying and obtaining all correct forms to be included in the application package (Figures 5.2 and 5.3). These forms (including checklists) are available online and are periodically updated as CIC policies change. According to John, the difficulty arises from the accumulation of ‘expired’ forms which are not always removed from the CIC website.

…there's a lot of paperwork, and you'll find a file online that says “this is the form you need” and will have a date on it. But it doesn't have a date that it's good until - it has a date that it was good starting. So we did multiple things following the wrong…you know, map, essentially. [...] [T]here’s a checklist that's a document checklist and it asked myself and my [...] sponsor to fill out a form. We spent weeks doing that. And filling out some of those forms is very invasive – you have to [...] put your former partners’ new address, things like that, you know? So then all of a sudden you’re going, filling out
forms found online only to later find out there has been an update, but this old expired form was still available online. [...] And then we realized “oh, there's a new checklist that looks very similar, but has a different date on it” right? That’s all you should need – it should look exactly the same but as long as the date is different, that’s all they needed to do. (John, In-Canada PR Applicant, no TB, emphasis as per participant)

John argued that without an explicit expiry date on all immigration application forms it becomes impossible for applicants to discern the ‘old’ versions from the ‘new’, leading to a potential waste of time, money, and effort on the part of the applicant from having filled out the wrong form. While the internet has facilitated global access to CIC application forms and materials, the deficiency in management of this online content has ironically made the identification of these forms, and the completion of the application, more difficult for some individuals.

The second challenge experienced by applicants was a shortage of available information to assist in guiding applicants through the application process (Figures 5.2 and 5.3). Despite CIC stating that “[i]f you follow the instructions, you should be able to fill out the forms and submit them without the help of a representative” (CIC, 2017b), many participants struggled during the process. Not only was there a lack of information available online, but there was also no help centre available to applicants during the application process:

I wish also there was, like, a place where you go personally and be like, “I’m confused because of this,” and you can state exactly what your situation is and have someone on the other end know what you’re talking about and what...you can do, what your next step is. [...] I’m trying to do things the right way and I’m trying to get the information; I look online, I call, I call again, and I call again, but every time I search I get a different answer. (Jane, “Removed” In-Canada PR Applicant, LTBI[?])

...you know, I'm educated, my level of English is pretty [good], my level and understanding of how things work is pretty good, too. But I guess with some people it can be really, really confusing. And it’s already pretty confusing for me sometimes, even though I’m not the stupidest person. So I would say yes, availability of information and support [is missing]...Sometimes just to get someone on the phone [is difficult] also because when you call them, unless it's really, really, extremely important, it's impossible to get someone on the phone to help you out. (Eve, In-Canada PR Applicant, LTBI)

Both of the above responses are examples of the difficulties each participant faced as they tried to successfully complete the immigration process. What is telling is that both Jane and Eve are
university educated and are fluent in English; if these educated and very capable individuals reportedly had problems accessing information from CIC, it is not difficult to imagine the barriers that more vulnerable applicants (i.e. not highly educated, not fluent in English or French, who have limited access to resources such as the internet, etc.) would have to overcome as they move through the immigration process.

For Jane, the challenge associated with lack of assistance throughout the application process was exacerbated when she contacted CIC officials by telephone for clarification. On multiple occasions, Jane was given incorrect information (including being sent the wrong application form) and instructions for proceeding with her application:

…it’s that miscommunication that when you talk on the phone [some] people are rude to you, and […] every time I call for something, I call three times, and all three times I get different answers. […] I cannot rely on just one answer…Yeah, I called three times; I also have people listen to my call so that I assure myself that I’m hearing the same thing! ‘Cause the miscommunication aspect of it is huge. […] Every time I search I get a different answer. So…it’s hard to trust the system, and it’s hard to rely on them ‘cause they all say different things. (Jane, “Removed” In-Canada PR Applicant, LTBI[?])

Although Jane was the only participant in the study who experienced such blatant repeated instances of misinformation from CIC officials, several others shared in the struggle, frustration, and confusion resulting from what they described as an “impersonal” application process. Due to the difficulty in navigating the immigration process, as well as having to correct errors resulting from following erroneous advice, John and Jane sought out legal council as a last resort at their own expense. As the data reveals, the scarcity of guidance available to immigration applicants and the potential for misinformation can have significant negative consequences: i) it can jeopardize an applicant’s progress through the immigration process; ii) it can undermine their potential to successfully immigrate to Canada; iii) it can result in unnecessary additional financial cost, and lastly; iv) it can eventually lead to the erosion of trust in CIC and, by extension, the Canadian government in general.
4.1.2 Facilitators

Despite the numerous challenges, participants described several instances that were believed to have facilitated the application process. First, in John’s case, some of his application documents required authentication by the Canadian consulate, which, if submitted through traditional channels, would have been very time consuming and would have delayed his application (Figure 5.2). Instead of mailing in his completed forms to the consulate, however, John was advised by border officials during his latest entry into Canada to proceed as follows:

“Get your stuff together, make sure that it’s all in line, and then [...] bring it back to a border agent instead of just sending into the consulate”. [...] “[I]f you bring your fully completed application, we can look at it and bring it to our chief and they can sign off on it, and then you’ve legally done what they’re asking you to do at the consulate”.

(John, In-Canada PR Applicant, no TB)

This encounter at the border crossing and the personal advice he was given was a stroke of luck for John, as it enabled him to have his documents verified and authenticated in person by border officials. Even in this case, John was fortunate; although he was told the process “could take up to four weeks once you hand [the documents in] to the border [agent]”, to his surprise, they were able to complete the process “in an hour and a half”, essentially saving John up to “eight months” of processing time had he gone through traditional channels (via the consulate).

Second, family support was also cited as a source of help for participants. For those who were sponsored, the responsibility for compiling the application was shared between both the applicant and the sponsor; working together on an application would likely increase the probability of completing it successfully. Others described receiving logistical help (i.e. assistance in making appointments, helping to arrange payments of application fees, lending money) as well as psychosocial support and encouragement from family members (Figures 5.2 and 5.3).

4.2 Step 2: Immigration Medical Exam (IME)

All overseas Permanent Resident (PR) Applicants and Refugees are required to undergo an Immigration Medical Exam (IME) prior to departure for Canada. Similarly, all in-Canada PR Applicants (with the exception of those who entered Canada under the Live-in Caregiver
Program) must complete this medical screening process. For Temporary Resident (TR) Applicants, a medical exam is mandatory only for those who intend to either work in an occupation where the protection of public health is necessary, stay in Canada for longer than six months, and/or if they have lived in, or traveled to, one of 146 “Designated Countries” (defined as having an incidence of TB of 15/100,000 or more as per the WHO) (Charbonneau, personal communication, Dec. 2016; CIC, 2016b). Conversely, TR Applicants living in one of 133 non-Designated countries, or those visiting for less than six months, are exempt from having to undergo the IME. Only a CIC-designated physician called the Panel Physician (PP) has the authority to conduct the medical exam, which must be completed and “passed” in order to be admitted to Canada as an immigrant (CIC, 2013d).

4.2.1 Upfront Medical Exam

For certain immigration categories, applicants have the option to undergo an Upfront Medical exam, meaning that they can report to a PP and complete the IME prior to submitting their application to CIC. Those individuals who choose the Upfront Medical must submit proof of completion of the IME as part of the application package; those who do not undergo the upfront IME must submit their complete application package and await further instructions. Once the complete application package has been received by CIC, a referral for the IME is issued, directing the applicant to report to a PP within 30 days of receiving the notification (CIC, 2015a).

Undergoing the IME upfront was perceived to have expedited the application process by participants who chose this pathway (John and Eve) as they believed that waiting for a referral would have further delayed the application process. Based on the responses from participants who did not undergo the upfront IME (Jane, Stacey, Andrew, Michael, Zara, Memphis), this fear does not appear to be substantiated. However, as the results of the analysis suggest, both upfront and later IME referral approaches might be a hindrance to the application process depending on the individual situation. John’s situation is the only documented case in this study where the upfront IME presented a serious problem; his goal was to submit a complete In-Canada PR Application to be considered for a limited 1-year pilot program, qualifying him for an open work permit while his PR application was being processed. The unexpected delay in the completion of his IME (described in more detail below) jeopardized his ability to compile the entire application package and submit it to CIC before this deadline.
4.2.2 Step 2A: Conducting the IME

The main purpose of the IME is to assess whether an applicant has any conditions that are: “a) likely to [pose] a danger to public health; b) likely to [pose] a danger to public safety; or c) reasonably [...] expected to cause excessive demand on health and social services” (Charbonneau, personal communication, Dec. 2016). The IME consists of a review of the applicant’s past medical history, as well as a physical and mental examination involving the collection of “client biodata” performed by Panel Members, or PMs (the term “PM” refers generally to medical professionals, including physicians, radiologists, laboratories or specialists, whom have received CIC authorization to “perform IME-related activities”) (CIC, 2016a, Chapter 1: Acronyms and Definitions). Applicants, or IME clients (CIC, 2016a) are screened for signs and symptoms of certain conditions of interest, including TB, through age-specific laboratory tests and chest x-rays, all conducted by designated PMs (CIC, 2016a). If the chest x-ray reveals abnormalities consistent with or suggestive of active TB, the PP must arrange for an urgent referral to a TB specialist for assessment and treatment and notify CIC. If LTBI is suspected or if the applicant has a previous history of TB, the PP must submit this assessment to CIC and await further instructions from the Regional Medical Officer (RMO).

4.2.2.1 Barriers: Application Delays

Participants listed a variety of challenges encountered during the IME. One of the most common complaints was insufficient information about the IME resulting in uncertainty and confusion about what the IME process entails (Figures 5.2 and 5.3). This was particularly true for some individuals undergoing the Upfront IME (John and Eve). With difficulties in accessing information (as described in the previous section), some participants felt that without being aware of what procedures and exams to expect, one was left to “figure it out on your own as you go” (Eve, In-Canada PR Applicant, LTBI).

Another perceived problem reported by some participants was application delays due to long wait times for, and between, IME appointments (Figures 5.2 and 5.3). Eve reported having to wait 2 months for her initial appointment but was promptly booked and seen by the PP during follow-up. In contrast, while John and Jane were booked and initially seen within a matter of days, they experienced repeated delays thereafter. They both complained that during follow-up it
was difficult to make contact with the PP’s clinic because “they barely answer their phone, [and] if you leave a message they never get back to you” (Jane, “Removed” In-Canada PR Applicant, LTBI(?)); the clinic was also closed for vacation for three weeks without prior notification to IME clients, further delaying the immigration application process for them. These examples describe how customer service issues create challenges during the immigration process.

4.2.2.2 Barriers: Access to CIC Clinics

Access to CIC-approved clinics may also be difficult for some applicants. For most participants living in or nearby large urban areas, getting to a clinic for the IME was relatively easy (i.e. Sunny, Memphis, John, Jane etc.); for Michael and Andrew, however, who lived in either a more remote area and in a city without any CIC-approved clinics, merely attending their IME appointment proved to be a logistical challenge.

That was very costly. It cost a lot, because we are from the province, ah, if you take a bus, it will take you ten to twelve hours to go to [the city]. Because there’s no designated clinic at [our] region […] and that’s the only three [CIC-designated medical clinics in the country]. […] So it’s, again, hard for us. But then again, we have to comply. We have to go, together, with [all of] my […] kids -- …It cost a lot.

(Michael, Overseas PR Applicant, old TB)

Maria: For us to do [the IME] […] is not easy; we have to take a train. First financial: we have to send [Andrew] money [from Canada], because it’s not like a few [currency] only – it takes 30,000 [currency] because the cost of everything we have to pay the doctor, where to stay for hotel, [have to take the ferry]; the time: we have to take 3 or 4 days to go there – we have work back home but we have to do it […] …[Andrew] doesn’t know how to go to those places so we have to bother someone to take him –

Andrew: A guide, a companion…

(Andrew [and his wife, Maria], Overseas PR Applicant, no TB)

As these responses indicate, some applicants need to go to great lengths to get to the CIC-designated clinics: They must take time off from work and arrange for travel and accommodations often not only for themselves, but also for others accompanying them. Under such circumstances, a seemingly straightforward doctor’s appointment turns into a difficult, lengthy, and expensive journey (Figure 5.2).
4.2.2.3 Barriers: Encounters with Panel Physicians

Several participants experienced difficulties as a result of their interaction with the PP and other PMs. The PP’s roles and responsibilities with respect to the conduct, practices, and relationship with clients are strictly outlined by CIC. The Canadian government mandates that PPs not elaborate on any results of the IME to the applicant except in cases “when they discover a serious disease not known to the client” (CIC, 2016a, section 3.1.5). If this occurs, the PP is expected to “perform their IME-related activities in a manner that is keeping with […] CIC policy” and “uphold professional and ethical standards by referring back to the client’s usual physician or to an appropriate specialist, upon request” (CIC, 2016a, section 3.1.5). Therefore, while PPs may diagnose a client with a significant illness or disease in the context of the IME, the counseling and medical care offered to the individual as a patient falls outside the PP’s role. CIC further restricts communication between the PP and the applicant, stating that PMs do not have the authority to assess or determine whether the medical conditions of clients are grounds for inadmissibility. More specifically, panel members do not have authority to give clients an opinion on their medical admissibility. That determination rests solely with Canadian immigration officers. (CIC, 2016a, section 3.1)

It is therefore not surprising that participants’ experiences of the IME ranged from positive, to neutral and uneventful, to negative. The most negative experiences described by participants appear to be in instances where the PP and their staff adhere most closely to these guidelines. Zara described her interaction with the PP as follows:

When I first visited the [physician], I told her that this is what I have been through, I’ve been treated for TB for, like, four months, and she was like, “Yeah, but then CIC would decide”, okay? So they kind of scare you, right? So, [CIC] don’t want them to share everything with the patient, but then, just, “okay, this is just a procedure, okay? […] We have to just ensure that you don’t have a infection. Even if you have, it’s not going to --“ […] Nobody tells us. Nobody, you know, informs this aspect…that even if you have TB, you would not be denied the visa; you can still join your family – all you have to do is go through the treatment. That makes the life so simple and easy, right? […] The importance of screening and the outcome is not being shared. Because I remember – I have asked this question to the panel physician and I don’t think she answered my query at that point in time. (Zara, Overseas TR & In-Canada PR Applicant, LTBI[?])
The non-disclosure between PPs and clients about their potential diagnosis or its implications for the immigration process generates unnecessary fear and perpetuates anxiety for applicants (Figures 5.2 and 5.3). Participants described the stress and anxiety they felt thinking they might be sick, and worrying that their diagnosis might prevent them from reuniting with their families and starting a new life in another country.

Another difficulty was described by John who, during the IME, presented the PP with information (including a chest x-ray) for a condition that he had been investigating extensively (and covering these medical expenses out of pocket) in the year leading up to his IME. Instead of engaging John and checking the results of his previous examinations to assess whether further testing was necessary, the PP dismissed his concerns and completed the IME form in a way that irreversibly set John on a trajectory of extensive follow-up testing.

...because of [my previous job] I just had a lot of things done, including the x-ray, and I knew about [the abnormality], I knew that it was gonna be a red flag. I told my [PP], “I know about this, it’s a red flag,” and he told me to tell the x-ray technician...What?! [...] I had a disk with the x-ray on it and said, “look at it", and he says “no, hand it to the x-ray technician”. The x-ray technician...took it...probably didn't look at it, and I was called in a TB test because of the abnormality on my x-ray. And then [...] I went in to [the PP] and I said, “this is exactly what I expected to happen. You didn't listen to me. It’s pre-existing and it’s going to show up as a problem,” and he said, “oh yeah, I probably should have listened to you and looked at it”. (John, In-Canada PR Applicant, no TB)

The testing John was required to undergo as part of the furtherance process (described in detail in the next section) delayed his immigration application by several months and caused additional challenges for him along the way (Figure 5.3). Had the PP used more discretion, these delays may have been avoided in John’s case.

Other difficulties described by participants were clinic-specific. These related to the perceived unprofessional conduct of staff and other PMs performing diagnostic tests, which in Jane’s case left her feeling “shitty, shitty, shitty”. She described being physically manipulated by the panel radiologist in a way that made her feel “like a cow in one of those, like, farms where they put you in your little cubicle and they move you around” (Jane, “Removed” In-Canada PR Applicant, LTBI[?]). While this type of medical conduct is not necessarily reflective of all clinicians, this
account demonstrates that for certain individuals, the IME process can have lasting psychosocial effects such as embarrassment, stress, and stigma.

4.2.2.4 Facilitators

In light of the challenges identified at this stage, participants recounted several incidents which they believed facilitated the IME process. First, given that all costs associated with the IME (as well as travel to and from the clinic) are the responsibility of the applicant, the financial burden may be significant for some. It therefore comes as an unanticipated and welcome gesture if a clinic decides to wave part of their fees, which happened by chance to Eve who was not required to pay for a follow-up x-ray (Figure 5.3).

Second, a few participants recounted positive experiences during their IMEs where PPs provided counseling or support beyond their CIC-mandated roles by communicating with the applicants more openly (Figures 5.2 and 5.3). Here is how a couple of participants described their experiences:

…the doctor told me at first that I don’t need to worry too much. Like, [TB] only affect the visa waiting time. But, like, I don’t have [a] health problem…

(David, Overseas International Student, no TB)

As I said, you know, they tried to do everything to help me out and to make me feel better. They’re like, “okay, on a scale of 1 to 4 you’re maybe a 3, but you’re not a 4 so it’s fine.” I’m like, “Okay, okay”. They were trying really hard to be nice and helpful and reassuring, so that was good; that was a good experience.

(Eve, In-Canada PR Applicant, LTBI)

It is apparent that when PPs communicate with the applicant and reassure them about the implication of the IME results for the immigration application process, it helps to minimize the stress and anxiety that applicants may already be experiencing. A similar effect is achieved when applicants have friends and family who can provide support at this stage (i.e. logistical support by helping them locate the clinic, psychosocial support, or financial support to help cover the cost of the IME).
4.2.3 Step 2B: TB Furtherance

The TB furtherance process refers to further investigation of an applicant by a TB specialist in cases when TB infection (whether active or latent) is suspected. This referral can be initiated either by the PP (if active TB is highly suspected during the IME) or by the RMO after an initial assessment of the IME report has been submitted to CIC (CIC, 2016a). If CIC suspects active TB or requires further information to complete the medical assessment (such as verify any abnormalities indicative of TB), they will direct the PP to arrange a referral for the client with a TB specialist to undergo additional testing.

The primary aim of the furtherance process is to rule out active TB. The acceptable diagnostics include the collection of sputum “on 3 consecutive mornings” (CIC, 2013c, p. 3) in order to perform a culture test (which takes up to 8 weeks) and to check for drug sensitivity. If culture tests are negative, the chest x-ray must be repeated after three months; if, however, the applicant cannot produce sputum, a chest x-ray must be repeated six months after the initial x-ray to ensure stability (CIC, 2013c). If active TB is confirmed, the applicant must complete treatment under the care of the TB specialist in accordance with the WHO or Canadian Tuberculosis Standards (which typically lasts between 6 and 9 months). The PP is required to provide the RMO with interim reports and x-rays during the course of the treatment until the applicant is cured (CIC, 2013c). If, however, the test results come back negative for active TB, the furtherance process is completed. Any findings (i.e. suspected or confirmed LTBI, past history of active TB, etc.) are included in the report.

4.2.3.1 Barriers: Surprising Diagnosis

Participants in this study encountered numerous challenges during the furtherance process, primarily relating to delays. First, for individuals with no previous health history or known exposure to TB, the referral for TB furtherance is in and of itself an unexpected delay (Figures 5.2 and 5.3). This referral is often a time-consuming multi-step process. In Zara’s case, for example, it had taken two months since her initial IME appointment before a referral to a TB specialist was made. She was first called back for a follow-up x-ray with the PP after one month, then had to wait another month for the x-ray to be read and a referral to a TB specialist made. Others reported similar delays:
I had to do the x-ray first back home – it was done I think…October? Yeah, October. […] And I had to wait...for the couple of months – like two months – ‘cause, you know, there’s a pretty long line of immigrants or applicants for Canada back home. So I had to wait for my turn for them to read the x-ray, and then they have to – when my turn comes, the x-ray would be, you know…ah, would have taken so long. And I had to do it again ‘cause they had to see if there was a development or something like that, so I had to do it over and over a couple of times. (Memphis, Overseas PR Applicant, LTBI).

…it took some time for the visa office to tackle this…from this hospital to another hospital. Yeah, [so it was] arranged by the visa office. Yeah, because the hospital I get tested, I get the original test, needs the feedback from the visa office to arrange me take the [sputum] test in another hospital. (David, International Student, no TB)

These delays in part result from the chain of communication between the applicant, the PP, and the RMO: the PP submits the IME report to the RMO; the RMO reviews the IME report and informs the PP of the need for TB furtherance; the PP notifies the applicant and refers her or him to a TB specialist. Moreover, some participants were faced with having to wait for the referral to a TB clinic even after the RMOs decision for furtherance was made (Figure 5.3):

I pushed [the receptionist at the PP’s office] and said, “would you please make [the referral] as soon as possible? Please make it as soon as possible; please make it as soon as possible,” and she literally didn't the first two times that I called to follow up. I left [the office] […] I called twice. She still hadn't made the appointment. So I called the third time and said, “please make the appointment”…knowing that these things all take [time], and I was gonna be gone for two weeks…And [our] wedding – once the wedding stuff started I wouldn't have really been able to show up to clinic appointments, so… […] that's just it. Like, knowing that you have a timeline – pushing it forward is all I can do. (John, In-Canada PR Applicant, no TB)

The effects of timelines and delays become even more significant for applicants who are undergoing major life events, like, in John’s case, marriage. For others, like Zara, it was not so much the delay in referral that was troubling, but rather the very act of being referred for further TB testing. Since TB furtherance is initiated under the suspicion of active TB, this label and process can have stigmatizing effects on applicants in unexpected ways (Figure 5.2):

…the stigma is definitely there. Because the first time I was asked to go through to get my x-ray done again, because they thought I might have an infection, I got a job offer
which was kept on hold, you know, back in [my country]. It was for a US company – I [was] required to travel a lot, so it was kept on hold until I gave them all the tests and I was given a clearance. […] So, I was shocked because I was supposed to start working on a particular day, and then they received the medical report for the pre-employment examination that I have to go through and they told me that, “Okay, your chest x-ray is not normal and we have to keep your, you know, job offer on hold until you clear your medical examination.” So it affects. It affects.

(Zara, Overseas TR & In-Canada PR Applicant, LTBI[?])

Both of these accounts identify ways in which the furtherance process can interfere in applicants’ day-to-day lives outside the context of the immigration process, and they bring to light some of the real social and material consequences that these processes can have for people. While delays are a normal part of the Canadian health care system, particularly for specialized care, in the context of immigration and settlement, being in a liminal space between citizen and non-citizen had significant effects for how participants experienced this process.

In the context of the immigration process, however, the effects of this delay varied. For some participants, like Eve, the delay was inconsequential. While some others were not particularly devastated by it, they did perceive it as “a hassle” (Memphis, Overseas PR-Applicant, LTBI). Yet others, such as Sunny and David who applied for immigration as international students, were more seriously affected as the delay caused by referral for TB furtherance jeopardized both applicants’ ability to obtain their visas before the start date of their academic programs (Figure 5.2). Although David was fortunate enough to complete the IME and TB furtherance process a few days before his school started, Sunny was not and was forced to defer the start time of his program by one semester.

4.2.3.2 Barriers: Non-Disclosure

The second challenge identified at this stage of the immigration process refers yet again to the restrictions imposed by CIC on communication between PPs and clients, specifically pertaining to the referral for TB furtherance. According to CIC, if clients inquire about the TB furtherance process after the request for further investigation is made,

…panel members are not authorized to explain or justify such requests. They should simply explain that the request came from CIC, that the panel physician is only a contact person between CIC and the client, and that the client should contact his/her visa office to obtain additional information. (CIC, 2016a, section 3.4.5, emphasis in original)
This lack of communication and counseling can have both a direct and indirect negative impact on applicants’ emotional wellbeing. In Zara’s case, it was the direct interaction with the PP that she found troubling:

…the panel physician in [my country] […] didn’t make me that comfortable. I don’t want somebody to give me, like, you know, be very open, because I understand you’re working for CIC: you have to keep everything confidential; you’re not supposed to share the reports and everything with me. But there is something called as making the person comfortable, you know? […] Because I’m applying for certain thing, you should not…create a stigma around that thing so that the person feels, “oh my god, what’s going to happen? Why I am going through all this thing?” There was no counseling. There was nothing that she spoke to me about. It’s like, “okay, this is what we are doing because CIC is asking us to do.” Why, you know, there was no discussion about it? […] So that kind of, you know, talks, that kind of communication is kind of missing…

(Zara, Overseas TR & In-Canada PR Applicant, LTBI[?])

Moreover, because the furtherance process is not explained to applicants, people are completely unaware about what it entails (e.g. the order and types of procedures they may expect) or how long this process is expected to take (Figures 5.2 and 5.3). Starved by the lack of communication and thirsty for information, applicants turned to various sources in an effort to better understand their situation. While some, like Jane, were fortunate to have a credible source (Jane relied on a close family member who happens to be a physician) that could explain the procedures involved in the furtherance process, others were not so lucky; a couple of participants (Zara and John) described turning to alternative sources, such as blogs and random internet searches, in an effort to find answers. Although this offers an opportunity for applicants to learn from others’ first-hand experience, this finding is troubling given the potential it creates for the circulation of misinformation from these unofficial sources. In this instance, applicants may come away with false expectations of the process, eventually resulting in greater disappointment and stress when their expectations are not met.

4.2.3.3 Barriers: Accessing TB Clinics

A third difficulty encountered by participants was once again associated with the location of TB clinics. Similar to CIC-designated clinics, some TB clinics located closer were more easily accessible than others (Figure 5.2). Moreover, depending on the individual case and type of tests
performed, applicants may have been required to attend the clinic a few days in a row, as reported by Andrew and Memphis:

Maria: We have to go to next city and stay there overnight for 3 days. […] Today is the sputum, then we have 3 days in a row.

Andrew: Next day is different test, next day is x-ray, scan, sputum…

(Andrew [and his wife, Maria], Overseas PR Applicant, no TB)

…I had to, like, go back and forth to the clinic – the immigration clinic – to do the actual sputum test every morning. And get this – my work is at eight in the morning – I had to go to the clinic, like, around seven and, as I told you, the commute there is horrible…So, you can only imagine, like, I did that test for a week.

(Memphis, Overseas PR Applicant, LTBI)

In addition to attending TB clinics, applicants had to cover the cost of all tests (laboratory tests and chest x-rays), doctor’s visits, treatment (if applicable), registration fees (e.g. if a clinic was located in a hospital which required an additional registration card), as well as travel and accommodation (Figures 5.2 and 5.3). These fees were an additional expense for applicants on top of the cost of the IME:

I had to pay twice. […] Yeah, twice. So it’s like twenty thousand pesos – Philippine pesos – altogether. So not only it is time consuming, also it’s, you know, like, a financial pain back home. Not so easy. I mean, if you convert it to Canadian dollars then it would sound okay […] but of course, when you’re earning the same currency back home it’s different. (Memphis, Overseas PR Applicant, LTBI)

While some individuals may have expected and prepared for this additional expense, the cost associated with the furtherance process may have come as an unexpected shock to those who have never had a history of TB. In essence, completing the furtherance process may be a significant financial burden for some applicants. The unexpected challenges faced by participants in this study highlight that not everyone can afford to immigrate.

Fifth, the time delay to diagnosis at the TB furtherance stage was similarly challenging for many participants. In Canada, the standard tests performed to rule out active TB (which includes chest radiography and microbiological laboratory tests, including sputum smear microscopy [PHAC, 2014a]) require up to two months to obtain a definitive diagnosis. Not only does this additional
...for so long I didn’t know what was going on and I was really stressed, very anxious. I’m like...okay what’s going on? I have something on my lung, what if it’s cancer? What if it’s-- you know? My imagination just runs wild and I’m wondering what it is. So first I was very stressed, very anxious, and also all of the waiting time, it’s just…”okay, we think it’s that, but we have to do an exam and it’s going to take two months to process”, and then you come back and then “okay. We think...so we are pretty sure it’s the tuberculosis and, but it’s not positive, so then we need to do the skin test and you need to come back”; and then, “okay, now we need to test your lung and maybe you’ll have to come back” or-- and you know, it’s always waiting time, so this is...I hate waiting. So maybe it’s personal, but it’s just...anxiety, stress, waiting is...it’s not great. I really hated this part. (Eve, In-Canada PR Applicant, LTBI)

Not only did applicants have to wait for test results, but some were also required to repeat the same diagnostic tests in different facilities. Prior to her referral to the TB specialist, Eve provided an induced sputum sample at the PP’s office; this test, however, was either not accepted or acknowledged by the TB specialist, and she was required to undergo sputum induction a second time (Figure 5.3). Having to comply with these requirements left Eve frustrated and confused about the perceived redundancy, which she described as feeling “like it’s always ‘rinse and repeat’”. Her account brings to question the efficiency of the IME / TB furtherance process, suggesting that some applicants may be unknowingly wasting time and money to repeat the same tests in different facilities.

Given the potentially extensive cost of completing the furtherance process, three participants described instances that were helpful in this regard. After a couple of exhausting attempts at induced sputum collection, Zara was unable to produce an adequate sample. Recognizing the limitations of the test, the TB clinic offered to refund Zara the fee for the test (Figure 5.2). Although she could not recover the hospital registration fee to attend the clinic, she was happy with the reimbursement as the test itself cost “double the amount of [the] initial [immigration medical] examination” (Zara, Overseas TR & In-Canada PR Applicant, LTBI[?]). John and Jane, on the other hand, both had to undergo the TB furtherance process in Toronto and were fortunate...
enough to not have to pay additional fees; given that neither of them had valid Canadian health
coverage, the cost of their consultations and tests at the TB clinic were covered under the TB for
Uninsured Persons Program (TB-UP) (funded by the Ministry of Health and Long Term Care)
(Toronto Public Health, 2017a) (Figure 5.3).

4.2.4 Step 2C: IME Medical Clearance

Once active TB has been ruled out (or cured), the IME and TB furtherance processes are
complete. The TB specialist must provide the PP with a final written report and includes copies
of diagnostic tests (as outlined in the Specialist’s Referral Form [CIC, 2012d]), which the PP
forwards to the RMO. Once CIC receives these files, the RMO conducts a final immigration
medical assessment; those “applicants who pass a medical examination“ receive a medical
certificate, which is valid for 12 months from the date of their final medical assessment (CIC,
2013d).

4.2.4.1 Barriers: Unclear Instructions for TB Specialists & CIC Status

The successful completion of this last step of the IME depends on the cooperation and
communication between the TB specialist, the PP, and the RMO. Unless each one of these actors
fulfills their role and follows all steps correctly, the applicant cannot obtain her or his medical
certificate and the immigration application cannot be processed. Unfortunately, several instances
of errors were documented in this study resulting in lengthy delays for applicants (Figure 5.3).
The first was a result of poor communication between the referring PP and the TB clinic where
applicants completed their furtherance process. While it is the PP’s responsibility to ensure that
“specialists and facilities providing supplemental tests understand that the request for additional
information is only for a medical evaluation in the immigration process” (CIC, 2016a, section
3.1.2) and should notify the specialists which types of documents are required to complete the
IME for submission to CIC, this did not occur in two cases. After completing TB furtherance and
obtaining verbal clearance from the TB specialists, both Jane and John became concerned after a
period of time without contact from CIC, prompting each to follow up with their PP to ensure
that their IME results had been submitted. To their surprise, they both found out that while the
TB specialists had submitted a final report, the PP was still waiting for x-rays; this requirement,
however, was not communicated to either the TB clinic or the applicants. Although this step is
not meant to involve the applicant, both John and Jane described having to personally intervene at this stage of the process by investigating the cause of the delay, having to negotiate between the TB and PP clinics, and, after identifying the problem, repeating the chest x-ray (in Jane’s case, at an additional cost) and personally delivering the missing files to the PP to ensure that their IME was truly complete.

…so then things were taking long, nothing was being processed, and I was like, “what’s happening?” So I called [the panel physician] and I’m like, “What is taking so long?” And they’re like, “we need the CD with the chest x-ray.” And I’m like, “well, I took it to [the TB clinic] and then they kept it. I asked if I needed to take anything back and they said that they were gonna send something themselves.” And he’s like, “well, they haven’t sent it yet. They only sent, like, a paper saying that ‘no, you don’t have active TB,’” and I’m like, “Okay, well --- “...[Jane goes on describing a several week-long ordeal having to repeatedly call the TB clinic and the PP’s office to try and figure out what information is missing. Without any luck, after three weeks, Jane returned to the PP]…So I finally went, and I was like, […] “what do you need?” […] He’s like, “On this online thing of your application, I have to insert your first chest x-ray, then the report that says you don’t have anything, […] and then [the TB clinic] has to do another chest x-ray and that’s what I need.” I’m like, “Oh! So I needed to get another chest x-ray from [the TB clinic]!” He’s like, “yes.” And I’m like, “why doesn’t [anyone at the clinic] know this???” So I called them and [explained the situation] […] and the doctor said, “Well, we didn’t think it was necessary [etc.]” […] And I’m like, “I know, but online they need to insert the second chest x-...I just need-- “, and they’re like, “well, you can have [the panel physician] call me.” I’m like, “why am I doing all this legwork?! Like, shouldn’t you guys-- like, you guys are connected; you guys should be doing this,” you know? But I did it anyway just to make sure it was getting done. So I went back to [the panel physician] […] and I said, “they are not gonna do it because they didn’t think it was necessary.” He’s like, “well, I need one because if I try to submit this [online application without the x-ray], it won’t go.” […] And I’m like, “Okay, so then let me go get another chest x-ray from the same spot that I went to originally that is paired up with this clinic.”

(Jane, “Removed” In-Canada PR Applicant, LTBI[?])

As it turns out, the TB specialists at this clinic were unaware that they were assessing Jane and John as part of the furtherance process; instead, they were under the impression that these referrals were made in the context of Immigration Medical Surveillance (IMS) and, as such, were not aware that additional medical files or test results had to be submitted to the referring physician. What is even more troubling, however, is that the PP did not initiate any follow-up with the TB specialist or the applicant regarding the missing files, not even after the applicant had interjected and tried to rectify the situation; he did not at any point attempt to contact the TB clinic and inform them of the CIC requirements for these, or any future applicants.
John’s account was almost identical to Jane’s at this stage; he described having to undergo the same kind of investigation involving back-and-forth communication between the two clinics. His case, however, became more complicated: while his test results cleared John of both active and latent TB, the pulmonologist at the TB clinic recommended a follow-up after 12 months to ensure that there was no change to the unrelated abnormality detected on his chest x-ray. It is important to note that ruling out active TB satisfied the requirements of the IME, and the follow-up was scheduled only in the interest of John’s own health outside the context of immigration medical screening. Upon receipt of this report, however, the PP became suspicious and questioned the findings of the furtherance process. After submitting the missing x-ray to the PP, John followed up to ensure that his IME results had been forwarded to CIC, and was shocked to learn that it had not:

…over the phone [the panel physician] told me that, no, because [the pulmonologist] and I made an appointment for a year from now, they don’t believe that I’m actually cleared. […] [The immigration part has been satisfied], but because [the pulmonologist and I] made another appointment…they don’t know why and they can’t understand why so they want to have their own people look at it. (John, In-Canada PR Applicant, no TB)

Despite receiving verbal medical clearance from the pulmonologist, John was still waiting for his IME process to finish at the time of our second interview. Because his participation in the study concluded at the end of that meeting, it is not known how much longer his application was delayed as a result of the PP’s contestation of the TB specialist’s report. The effects of this miscommunication, however, are apparent and include significant and unnecessary delays, extra work, frustration and stress, and the potential for additional incurred expenses for applicants (Figure 5.3).

In addition to poor communication between the PP and the TB specialist, an unexpected change in status of a CIC-approved clinic can delay the medical clearance process for applicants. After completing his medical assessment, the clinic where Michael and his sons completed their IME ceased to be affiliated with CIC. After a long delay, Michael and his wife/spONSOR were eventually notified by an immigration officer that CIC had not received the medical exam results for Michael or his children. As a result, they all had to repeat the IME, which not only further delayed the immigration application process, but also resulted in additional costs (Figure 5.2).
4.3 Step 3: Application Submission & Awaiting CIC Approval

4.3.1 Submitting a Complete Application to CIC

Once the complete immigration application package has been assembled, it is submitted to CIC for processing. Applicants are warned that if an application package is incomplete, it “may be returned to you, the processing of your application may be delayed, or your application may be refused” (CIC, 2017c). The application package must not only be complete and correct, but all components of it must also be valid; some documents included in the application package, such as the medical or police certificate or other documents requiring certification, expire after a certain period of time. If any documents expire before they are submitted they will need to be re-issued or certified again.

4.3.1.1 Barriers: Logistical Challenges

Compiling a complete and valid application package proved to be difficult for several participants in this study. John described this aspect of the immigration process as a “logistical challenge” and was exasperated by having to be constantly “putting all the puzzle pieces together” (John, In-Canada PR Applicant, no TB). Given that his application had to be submitted not only before his visitor’s visa expired but also by a deadline that would qualify him for a pilot program, any delays that John encountered throughout this process (such as TB furtherance) posed a serious problem for him. For Andrew, on the other hand, this task was further complicated due to his financial situation: “There’s no money to get all the papers at the same time because I had to go to the other city to process all the papers…I didn’t have money to get all the papers all at once” (Andrew, Overseas PR Applicant, no TB). As a result, certain documents in his application package expired before they were received or reviewed by CIC; having to repeat the certification of several documents caused further delays of his immigration process and was an additional expense for Andrew.

Depending on the country and city where individuals are applying from, applicants may have the option, or may be required to submit their application via a Visa Application Centre (VAC) - a third party service provider which assists with the management of applications for temporary and permanent resident, study and work permits, and travel documents for CIC. VACs act as an
intermediary between applicants and CIC, providing “general information and administrative services” (VFS Global, 2017) to applicants. While the VAC is not permitted to provide information or “evaluative advice”, they do offer additional optional services including assistance with filling out immigration application forms. Moreover, once an application has been submitted, the VAC will assess it for completion prior to forwarding it to CIC; applicants are notified of any issues with their application and are given 5 days to submit any missing information. Although this option was available only to some participants in this study (Figure 5.2), all applicants would have benefited from this kind of service as it could provide verification of the application package in real time, preventing longer delays.

4.3.1.2 Barriers: Insufficient Information & Wrong Advice

This type of advice and feedback would have particularly served Fiona well. Shortly after her arrival in Canada, Fiona, a live-in caregiver, changed employers and was required to apply for a new work permit. Unbeknownst to her, there was a recent change in policy which affected the application process for temporary foreign workers. Months after submitting her application for a new work permit, Fiona was contacted by an immigration officer and notified that she and her new employer filled out the wrong application and had to reapply:

…the immigration officer sent an e-mail after three months…“you need to change again, because now it’s LMI4 [Labour Market Impact Assessment required to hire a worker through the Temporary Foreign Worker Program].” Then, my boss said, “why you didn’t tell me in the beginning, so that that three month…” you know? The three-- …wasting the time. So it started again, from the beginning. So we […] wait again for about three months for my LMIA. So that, until now, I don’t have working permit […] because it’s wrong!...And if they start again to prepare LMO [Labour Market Opinion], now LMIA for my boss. Before, LMO [application cost] one thousand [dollars]; then […] he paid another one thousand [dollars] because LMIA now.”

(Fiona, Overseas Temporary Foreign Worker, LTBI)

Had this error been identified before the application was submitted for processing, Fiona would not have been delayed in obtaining her new work permit and her employer would not have wasted $1,000 paying for the wrong application.

Jane’s situation was in some ways similar, yet more complicated and with more significant effects. Having been incorrectly advised by CIC officials to not renew her temporary work
permit after submitting her PR application, Jane ended up “falling out of status”. After finally obtaining correct information, Jane was emailed a link by a CIC official to an application that would allow her to reinstate the expired work permit which had to be submitted to CIC within 90 days. She completed the application and submitted it with approximately two months to spare. To her dismay, Jane received notice three months after submitting her application that it was “the wrong application and that [she is] out of the ninety day grace period and [that she] needed to leave Canada” (Jane, “Removed” In-Canada PR Applicant, LTBI[?]) (Figure 5.3). Sobbing through the interview, Jane elaborated:

…they also received my application, like, three days later ‘cause I sent it express! They open it to see, whatever, and then it sits on their office…until it expire[s], like, my grace period is done…and then it takes so long for them to send it back that there’s nothing I can do. You know what I mean? So…I could have easily also done something else in that time, you know, instead of sit around not doing anything.

(Jane, “Removed” In-Canada PR Applicant, LTBI[?])

Again, had CIC officials reviewed the application either before it was submitted or shortly thereafter and immediately communicated to the applicant that there was an error with her paperwork, Jane may have very well avoided having to go back to her home country.

4.3.1.3 Barriers: Expired Documents

Andrew, on the other hand, found himself stuck in a cycle of having to repeat expired tests and certificates:

Maria: After you submitted something it would take so long to know if what you’ve submitted is okay or not. So if it’s not okay you have to do it again, but because the old papers have already expired, you have to keep doing it all over again. You’re running after time. Don’t know if need some other papers to add to the ones you’ve submitted, and by the time we find out [they’ve already expired] […] so have to do it all over again.

Andrew: It’s a big expenditure.

Maria: And also the time. You have to run and run – it takes 4 years instead of 1 year because of doing [the exams and getting paperwork re-done] again

Andrew: 4 years or 6 years.

Maria: If you process everything and get notice right away, you get everything done within a year…It takes 3 years – it’s hard to run back and forth…I
was imagining “what’s going on?” The processing of the government back home…ugh! It was really tough!

(Andrew [and his wife Maria], Overseas PR Applicant, no TB)

These delays in communication, the repeated testing, and constant resubmission and reevaluation of Andrew’s files delayed his immigration application so much that the entire process lasted over four years before he was finally given approval (Figure 5.2).

4.3.1.4 Barriers: Systemic Problems

Another challenge faced by participants was postal service delays in receiving communication from CIC. Stacey and Andrew were sent notifications to undergo their IME (which are given a 30-day limit); both participants, however, reported receiving this notification only days before the deadline, leaving them unable to fulfill these requirements and causing additional delays (Figure 5.2). After this experience, Stacey opened up an email account solely for the purpose of facilitating communication with CIC.

Lastly, some participants also experienced processing errors by CIC. Michael was required to resubmit his and his children’s applications after being notified by immigration officials that some of their files could not be located (Figure 5.2). He reported having to resubmit their files a total of 3 times and, due to all the delays, waited 5 years for their applications to be approved. Jane, on the other hand, was repeatedly contacted by CIC who erroneously prompted her to submit various parts of her PR application, such as fees and IME results, after she had already submitted them. Although immigration officials eventually admitted their mistakes, their disorganized operation caused unnecessary stress for the applicant.

4.3.2 Application Processing Time

Application processing times vary greatly and depend on the immigration program, class, country where the application is being submitted, and the number of applications under review at any point in time (CIC, 2016c). Estimates provided by CIC are only meant as a guideline. While recent policy changes have reduced some processing times (IRCC, 2016a), at the time of this
study applicants’ processing times could range from as little as a few weeks (for study visas) to as much as 26 months (for permanent resident sponsorships) (IRCC, 2016b).

The interval during which applications are under review is a time of uncertainty and stress for applicants as they await the final verdict on whether or not they will be admitted into Canada. This waiting period presents unique challenges for both overseas and in-Canada applicants. First, application delays for overseas applicants push back the date of entry to Canada. This delay may not be problematic for everyone, especially those who are not required to arrive in Canada by a certain deadline; for some other applicants, however, such as international students (Sunny and David), processing and application delays may interfere with their ability to begin their academic programs on time.

Others like Zara, on the other hand, faced an entirely different challenge as the processing delay interfered with her job back in her home country. Zara’s work required her to travel, but CIC was in possession of her passport while her immigration documents were under review. Given that the processing time exceeded her initial estimate, Zara had to request that her passport be temporarily returned to her for the duration of her work-related travels.

The effects of processing delays also had considerable impact on some applicants’ personal lives. Michael explained that his only purpose for moving to Canada was to be reunited with his wife. Due to extensive delays, however, Michael’s immigration application took five years before it was finally approved. It was therefore not surprising to hear how much his marriage had suffered given the amount of time the couple had lived apart from each other, ironically waiting to reunite.

In Stacey’s case, while waiting for her immigration application to be processed, Stacy unexpectedly became pregnant with her first child; she became pregnant a second time shortly before leaving to come to Canada. She described this life-changing experience in the context of immigration:

…I wasn’t pregnant with my [first child] as yet when my mom say [to come to Canada]. Maybe if the process was faster I would not have kids, then I would have been where I wanted to be right now…because I could go when my mom’s filed for me. […] My mom came [June 2011] […] and [I] end up getting pregnant in [2012]. I still didn’t get the [immigration approval] paper; I only got the paper after giving birth in [December 2012].

(Stacey, Overseas PR Applicant, old TB)
Stacey believed that the application delays to some extent contributed to the life circumstances leading up to both her pregnancies. Vice versa, her first pregnancy further delayed the immigration process as Stacey had to reapply to include her baby in the application (Figure 5.2). By the time this second application was processed and approved, Stacey found herself in another predicament having to promptly book a plane ticket to Canada:

…[when I] told my mom I got the papers, she tell me, “have you reached? You need to book a ticket. Now!” […] “Buy the ticket now? I don’t have the money for that ticket”. She tell me, “try to get it.”…Basically they asked me to book the flight before my son turned two because I have to pay for a flight for him too…I didn’t have the money. I took a loan, I said my son dad to [take] the loan first. He didn’t get enough. I went and take a loan, I didn’t even get enough neither. I was like, “oh, I need more money”, I had to take an other loan. With my other loan, I got more than enough money; I paid off my loan, I pay off my boyfriend’s loan…paid my ticket, and I was set.

(Stacey, Overseas PR Applicant, old TB)

Michael and Stacey’s accounts illustrate that in the time it takes for an immigration application to be processed (which can be up to several years), applicants’ life circumstances may change drastically. More importantly, however, people’s lives may change directly as a result of the application process itself, but these changes can in turn have real material effects that can subsequently contribute to further application delays. This demonstrates how sensitive the immigration application process is to certain changes in the life circumstances of the applicant (and vice versa). Under these conditions, it becomes apparent that the only way to prevent delays is to ensure that the information in the application package accurately reflects the applicant’s life circumstances at the precise point in time when CIC is ready to make a final decision about the applicant’s admissibility. Given how unexpected life can be, this is often beyond the control of the applicant.

In-Canada applicants described a different set of challenges resulting from prolonged processing times. The first was related to the precarious immigration status that some participants found themselves in, particularly those without valid or open work permits. Participants who were unable to legally work in Canada while awaiting immigration application approval described being trapped in a cycle of social and physical isolation resulting from forced unemployment (Figure 5.3). Some participants felt that they were just “sitting here without a purpose” (John, In-
Canada PR Applicant, no TB), and felt burdened and guilty for having to financially depend on others for support (i.e. spouse, family, etc.). Without their own income, John and Fiona both felt that they could not participate in many social activities because of the cost involved; others (John and Jane) struggled with having to pass up on career opportunities because they did not have a valid work permit. Under such circumstances, undocumented work became a real option for some participants. While after much consideration John decided against it, scared that if he were caught it would jeopardize his ability to legally immigrate to Canada, Fiona, however, felt that she had no choice:

\[\text{…because I’m still waiting for my paper, I cannot work. Because if I’m work, it’s illegal…because I don’t have a working permit. Yeah… […] But you know, this coming Sunday, Saturday I have a part-time – I need to do this because I have kids; I need to send money back home. But I know this is illegal…I know. […] I cannot rely only to my boyfriend! You know? So I need to buy, also the food! Because I’m free for the…house! I have to pay rent, you know? [Everything here costs money].} \]

(Fiona, Overseas Temporary Foreign Worker, LTBI)

This precariousness, as well as the choices some participants were forced to make out of desperation, had serious effects on applicant’s mental health. John described the stress and paranoia he faced while awaiting CIC’s decision about his immigration application.

I have this sense of paranoia that I’m not doing something right, or that there’s something going on in my application that is going to cause me to be rejected…It’s living in a different type of stress. Ah, I feel like I’m trying to build a shelter on sand, and they could, like a large wave, just wipe it all away…I’m really paranoid that someone’s gonna be following me, you know, to make sure that I’m living here. And to make sure that [my wife is really] my wife. To make sure that all of these things [I claimed in the application are true]…I’m concerned that someone’s following me and, you know, having heard horror stories about these things, I have nothing to be concerned about. Or do I? It’s like sitting in prison not knowing your date of execution…We know that the human psyche can’t survive in that type of situation. [My situation], it’s much lesser [compared to some other applicants]…but, uhh…it’s my life! It’s my existence! It’s what I’m going through, and it stresses me out. (John, In-Canada PR Applicant, no TB)

John and Fiona’s accounts highlight some of the difficulties newcomers living in Canada might face while waiting for their applications to be approved by CIC. The restrictions imposed on certain types of applicants coupled with the fear of rejection of their immigration application
emphasizes the remarkable degree of stress inherent to applicant’s precarious position during this stage of the immigration process.

4.4 Step 4: Approval of Application & Referral for Immigration Medical Surveillance (IMS)

After a review and assessment of a complete application, those deemed to have met the criteria for eligibility by CIC are granted temporary or permanent residency. For those required to undergo a medical examination, the results of the IME are also taken into consideration. While TB is considered by CIC to be a medical condition of public health significance (CIC, 2014a), a history of TB or confirmed / suspected latent infection are not grounds for rejection of an immigration application; the applicant may still be approved but a condition of entry is imposed on her or his file, requiring them to report to provincial public health authorities for immigration medical surveillance (IMS) upon arrival in Canada. The IMS is part of the Canadian Tuberculosis Prevention and Control Program and relates specifically to the referral of individuals identified by CIC “to boards of health, post-landing, for medical follow-up to rule out active TB and determine the need for treatment of LTBI” (OMHLTC, 2008, p.2). The referral for IMS is delivered to the applicant along with the visa / PR approval. In order to remove the condition of entry from their file, the applicant must comply with all conditions of IMS in accordance with public health protocols (CIC, 2014a).

IMS referral had various effects on participants in this study. For several participants, the referral was confusing and stressful, especially since they had just completed the IME and received medical clearance (Figure 5.2). Some participants, like Stacey, reacted in fear:

…when I got the letter in my passport saying that ‘contact public health as soon as you arrive’, I was like, ‘whoa. Why?’ That got me afraid. I was like, ‘I got this form saying I can leave, I got the visa – a one-way visa…why do I have to contact public health?’

(Stacey, Overseas PR Applicant, old TB)

For others, the IMS referral created doubt about the accuracy of their medical clearance as well as the state of their own health. Several participants explained that they suffered from insomnia due to anxiety and stress of this situation: “I have to wait, you know, to sleep at night. […] …when you know that you could have [TB], and still you have to wait for the results of the test and whatnot, it stresses you, right? Like, you couldn’t think straight…” (Memphis, Overseas PR
Applicant, LTBI). The referral was perceived as a sign that, despite receiving IME clearance, you might still be sick, but you must wait a long time to find out with certainty. Along the same vein, while Michael perceived the IMS referral as an indication of illness, he was more affected by the stigma associated with this label: “It really affect us...Especially my wife...is very embarrassed when she knows that I have that tuberculosis” (Michael, Overseas PR Applicant, old TB). Despite undergoing treatment and receiving medical clearance, because Michael was still required to continue with further testing after arrival in Canada, the stigma associated with TB persisted and continued to affect his experience.

Some participants were unclear about the potential implications that IMS might have on their immigration status after arrival. For instance, David sought information from informal sources (including friends and myself) to clarify whether this process will place any restrictions on his future career options in Canada. Awngshayi, on the other hand, who came to Canada as a government sponsored refugee, perceived IMS as a threat to her immigration status, associating non-compliance with these instructions as grounds for deportation:

...I got there very serious paper the from the government; within it, if I’m not take my medical checkup – follow-up – within one month, they can deported me. Is it written in the paper. I’m really worried. [...] And then, so for me is I’m scared! I just get into [Canada], I don’t wanna leave back, you know?

(Awngshayi, Government Sponsored Refugee, old TB)

Awngshayi’s reaction was particularly surprising and unexpected because, as a refugee, she is legally protected and exempt from being refused status on medical grounds; and yet her response demonstrates the effect that government-issued instructions relating to immigration can have on some of the most vulnerable newcomers as it may threaten their perceived sense of security as new Canadians.

4.5 Step 5: Arrival in Canada / PR Landing

As newcomers arrive in Canada, border services agents are required to complete a section of the Medical Surveillance Undertaking form and, if newcomers are not yet in possession of it, must provide a Medical Surveillance Handout instructing them to report to public health authorities either within 30 days (standard for newcomers with “inactive pulmonary tuberculosis”) or 7 days
(for “complex non-infectious inactive pulmonary tuberculosis”) (CIC, 2014a). The Medical Surveillance Handout provided to newcomers comes with the following warning:

Failure to comply with all the conditions […] may be reportable under the Immigration and Refugee Protection Act and could have a negative impact on [their] immigration status. For example, [a] visa or permit might not be renewed or extended until [the applicant] ha[s] complied fully with all the conditions [outlined]. Or [they] could be denied Canadian citizenship until [they] provide proof that [they] have complied with the terms and conditions [stated]. (CIC, 2014b, p. 2)

Beyond the aforementioned instructions and explanation of consequences of non-compliance, no further explanation of what the IMS process entails is provided to newcomers at this point; more detailed information is communicated only through public health authorities.

John was the only participant in this study who experienced serious problems at the port of entry to Canada. Prior to submitting his PR application, John was legally not required to formally apply for a visitors’ visa; due to an old criminal record, however, he was refused entry to Canada until he completed proof of criminal rehabilitation. As a result, John and his fiancé (at the time) spent several days in a border city completing the appropriate documentation before finally being allowed to cross into Canada (Figure 5.2).

While all other participants described their entry into Canada as uneventful, Stacey did recall her interaction with the border services agent as a distressing experience. In addition to completing the Medical Surveillance Undertaking form, border agents must remind newcomers that they are required to comply with the conditions of medical surveillance, which may come across as threatening: “…the thing that scared me [at the airport] was, he said: ‘You have to!’ He was like, “You have to! First thing tomorrow morning, you have to call!’…Give me time to breathe…I just reach…” (Stacey, Overseas PR Applicant, old TB). Moving to a new country is understandably a stressful process, as is interacting with immigration officials under normal circumstances; for those requiring to undergo IMS, receiving instructions from government officials in this context can exacerbate stress and perpetuate fears among this group of newcomers (Figure 5.2).
4.6 Step 6: Immigration Medical Surveillance (IMS)

4.6.1 Step 6A & B: Contacting Public Health & IMS Medical Assessment in Primary Care Practice

Once newcomers establish contact with public health officials, they become medical surveillance clients. The first step of medical surveillance involves an assessment of the client’s individual case. Next, newcomers must submit their Medical Surveillance Undertaking form to public health authorities. Once the form has been submitted, newcomers are mailed specific instructions for undergoing a medical assessment in accordance with IMS. In Ontario, in the absence of symptoms suggestive of active TB, newcomers are typically instructed to undergo a medical assessment with a primary care physician (either in the context of family practice or a walk-in clinic) within 3 months of obtaining their Ontario Health Insurance Program (OHIP) coverage (3-6 months after arrival in Canada). Public health authorities provide IMS clients with a form to be completed by the assessing physician and returned to Public Health. The current protocol for the medical assessment of individuals under IMS includes procedures such as sputum collection, tuberculin skin test (TST) (if necessary), and a chest x-ray (OMHLTC, 2008). Those clients with symptoms suggestive of active TB infection or with more complex clinical cases may be required to undergo a medical assessment sooner; in these cases, public health authorities will either assess the individual in one of their clinics or will arrange for an immediate referral to a TB specialist.

4.6.1.1 Barriers: Unclear Instructions for IMS & Fear of the Unknown

Participants faced several challenges at this stage of the immigration process. First, because contact information for public health officials is specific to the newcomers’ intended location of residence, those newcomers who do not remain in their original destination in Canada, like Awngshayi, may become confused about whom to contact in order to comply with the IMS requirements. Awngshayi described being relocated as a refugee to Saskatoon but moving to Toronto within her first few weeks in Canada. When she discussed the IMS with her caseworker in Saskatoon, she was told that she would have to complete the process in Toronto but was not provided with any details: “he didn’t tell me where to [go], what to do, how it is”. Instead, the caseworker told her, “You will find it out” (Awngshayi, Refugee, old TB). After moving to Toronto, Awngshayi visited a few government offices in search of instructions but did not
receive any useful information. She eventually ended up at an immigration centre. While the staff there was willing to help, they did not provide accurate instructions on how to proceed with IMS.

I finally got in to get that exam with this family doctor…it just referred to by this [immigration services] clinic. So I did the exam there – x-ray […] So for me, I thought that I’m already done the medical exams [for IMS]; I think the doctor will be going to do that, you know? Signed it -- No! The Public Health contact me again: “if you not to doing this, you really need to get the report you are missing and otherwise you will be deported”, you know? And I was, “oh, wow!” And then I have to go back to the [immigration services] clinic, and then they have to refer me to that doctor [again] who was so far away […] – I think almost two hours to go there! Okay, I go there again and then I have to eventually -- I had to fill it out the form and send [to] Public Health. That was I have to do but I didn’t know that - I think the doctor gonna to did it for me, you know? Doctor didn’t get it. And I don’t have the form neither because I-- Why? I don’t know that because I don’t have that form. And nobody explain me. As for me, I really wish that this [immigration service] explain me, you know? “You go medical checkup in there, you need to have a form, the doctor will do is this--”; no, they don’t explain me.

(Awngshayi, Government Sponsored Refugee, old TB)

Without any other information about IMS, Awngshayi followed the advice of this immigration services clinic and underwent a medical assessment. However, because she did not contact public health officials first, the procedures for the assessment were not followed appropriately. As a result, the participant had to return to the clinic to repeat the appointment and follow public health procedures. While there, she faced additional challenges. First, when the doctor was completing the IMS form, Awngshayi could not recall exact details about her TB history such as dates and medications she had taken. After explaining this to the physician, to Awngshayi’s surprise he responded: “‘You cannot lie. Answer everything. If you don’t answer correctly you can be deported. Do you understand?’” (Awngshayi). In addition to this frightening experience, despite having medical coverage under the Interim Federal Health Plan (IFHP), she was required to pay for her subsequent appointments out of pocket.

Only one times that they accept [the IFHP]; the rest I have to pay. They said only one time is cover from the federal government. […] …same doctor, same clinic. […] The second time when I go there, […] he asked me to pay. The third time is said to fill it up the form – he asked me to pay. […] “Why not is not cover?” [Awngshayi asked the doctor]. “Is not cover – only one time is cover” [he said]. […] …He don’t explain me anything – he just ask me to pay. So for me, I don’t understand anything at all. I just want to get it done so okay, I pay.
Awngshayi’s experience demonstrates how easily a newcomer under medical surveillance can be misinformed, sending her on a parallel, yet incorrect, pathway to completing the IMS process (Figure 5.2). Not having understood the IMS process, Awngshayi wasted time and money traveling to the clinic for repeat assessments. Moreover, despite having IFHP, the participant was unnecessarily required to pay for the follow-up visits with the same doctor. Had the medical assessment been conducted correctly the first time, Awngshayi would not have had to bear the financial burden of covering these medical costs. Ultimately, these mistakes cost her time and money and created unnecessary stress and anxiety.

The second challenge faced by participants at this stage comes from the burden of not knowing one’s own health status while awaiting IMS medical clearance. When combined with the stigma associated with TB infection, the fear of infecting others (particularly family members), as well as confusion about the requirements of IMS and its implications on immigration status, may motivate some newcomers to seek out “clearance” through avenues other than the ones described in the official Migratory Pathway. This was the case with Michael who described visiting a number of government offices and institutions (including two Service Ontario centres, a walk-in clinic, and a community health centre) in the first few days after moving to Toronto in search of instructions for completing IMS. He recounted his journey through the foreign city as a harrowing ordeal during which he had several stigmatizing encounters, some which left him in tears.

…so, I went [to Service Ontario], then they asked me what was my business. […] I gave him the medical surveillance [form]. “What is this all about?” he asked me. “Ah, it’s about my immigration papers. The immigration officer gave me that before we went here, so I have to comply with it.” “Yeah, I know. So what do you want me to do?” “I don’t know. This is my first time here in Canada, so please, help me what to do.” Then he asked me, “Are you infected with tuberculosis?” “Before I was infected, but now I’m okay.” Then there was her reaction…I don’t know what was that, just like that-- just let me go away. But he told me, “No, this is not the right office that you have to go. Go to the doctor or somewhere else.” “No, I’m just asking if you can help me where to go.” “No, no, no, just go away,” he told me. Just-- …So… that’s what happened. But… I feel very bad …just don’t know why is she talk to me like that. […] So I went out, with my tears falling down. (Michael, Overseas PR Applicant, old TB)
Michael described a similar encounter at another Service Ontario office at which he was told to see a doctor. With his sister’s help, Michael went to a walk-in clinic where he underwent a medical assessment and a chest x-ray; but because Michael did not have his OHIP at the time, he had to borrow money from his sister to pay for the doctor’s visit. Lastly, even after contacting public health and arranging for a medical assessment, Michael was consumed by the stigma and continued to seek out additional consultations in hopes of receiving medical clearance.

Accompanied by his sister, Michael attended a community health centre. He described sitting in the waiting area with a facemask, hunched over, his head hung in shame. After being observed by a physician for a period of time, Michael described the following encounter:

…I heard a voice coming from my left side. “Oh, this guy don’t have a TB.” …I look up, I see […] the doctor… […] “Remove your mask. You don’t have a TB because I’ve been observing you ten to fifteen minutes. Because if you have a TB“ – you know what I mean? […] – “you will always do the coughing or you have a fever or whatever. Because I know that symptoms.” […] …[T]hat was the time I think I was [on] cloud nin[e]. I was so happy. “Doctor, thank you.” Even for the short words, I was relieved. The pain that I am-- that is in here in me [Michael said, touching his chest], it’s all released – all the stress. Because every now and then, when I have to think, “what am I gonna do with this medical surveillance?” or something like that – it’s always on my mind. […] I can’t sleep. […] I only sleep – it will be two hours, then can’t; it’s hard to go back to sleep.

The burden that Michael carried from being labeled potentially sick was so great that it was manifesting itself physically as insomnia. Despite the hassle of repeated TB testing and the emotional and physical suffering that Michael endured during these encounters, he continued seeking medical clearance in order to “prove that [he doesn’t] have tuberculosis” (Michael). The relief Michael described at the end of his community health centre visit implies that the medical clearance Michael sought was not only for official purposes, but also for himself.

Even those participants who followed IMS instructions identified challenges with the process. Most participants initially believed that they were expected to undergo a medical assessment within the first 30-days in Canada, not realizing that the 30-day deadline applied only to contacting Public Health, which was stressful for newly arrived immigrants. Even upon learning that they had more than 30 days to complete IMS, many found it difficult to manage all the
requirements of medical surveillance during a very busy settlement period (Figure 5.2). With reference to CIC requirements, Memphis stated:

…whenever [CIC] want[s] something done, they want it done ASAP - they want it done, like, right now. Now! And, you know, there are a lot of things going on. I’m like, “can you-- can you just give us a bit of slack? Have some--, you know, give us a bit of a bigger time frame to do all the things?” (Memphis, Overseas PR Applicant, LTBI[?])

While several participants expressed feeling stressed from the pressure to comply with all requirements immediately after arrival in Canada, others, conversely, took issue with the recommended 3-month waiting period (until they obtained OHIP) as it further delayed their diagnosis.

…if I am speculated to have active TB or inactive TB, I should be looked after immediately. So, I was, like, a little bogged down because until I’m given a clearance, […] I was in doubt that I am having something, and that’s the reason I have to go through this medical examination every time, time and again. So, I was expecting somebody to look at me as soon as possible, give me a clearance because I am here to reunite with my husband, and I know there is a stigma around tuberculosis so I don’t want my husband to get infected in case I do have it, you know? […] I am planning to […] start a family – I don’t want to have a troubled pregnancy because of the infection… […] I landed in [August], […] and I got an appointment to see the doctor, you know, to decide whether I have infection or not in [March]. I cannot wait!” […] So if I am in doubt, I decided not to work ‘till I get my medical clearance; I decided not to start a family ‘till I get a medical clearance. (Zara, Overseas TR & In-Canada PR Applicant, LTBI[?])

Zara’s account highlights several points. As already mentioned, the referral for IMS itself puts people in doubt about their own health. Once they arrive in Canada, however, the instructed delay until medical assessment allows this doubt to proliferate. This doubt, in turn, plays a significant role in newcomers’ decision-making process and carries real material consequences for newcomers and their families. Under such circumstances, IMS can inadvertently cause people to intentionally delay important life decisions such as pregnancy or even getting a job (Figure 5.2). Eventually, because the fear of the unknown was not acceptable for Zara, after seeing her family physician she demanded an additional immediate consultation with a specialist to ensure that pregnancy was safe given her potential TB status; it was only after receiving this assurance that Zara felt comfortable enough to start a family.
4.6.1.2 Barriers: Unexpected Life Circumstances

Another challenge faced by some participants was a significant delay in the completion of IMS. Under certain circumstances, such as pregnancy, some newcomers may be unable to complete the necessary medical assessments required for medical surveillance (Figure 5.2). In this study, Stacey and Zara were pregnant at the time of their IMS. While pregnancy is a legitimate reason for postponing certain medical tests (e.g. x-rays), the delay to completion of the surveillance process was psychologically and emotionally taxing for participants; not only did the women describe stress from being “under surveillance”, but they also worried about the perceived negative implications of not being able to complete IMS on their immigration status.

…[to] find out I was pregnant and constantly getting that letter saying I ‘have to be tested’ was scary. The very first one said that I need to get tested or else I may not be unable to get my PR card. But I guess they receive my things from [my clinic] here saying that I was pregnant, I couldn’t go for the x-ray… […] only scary part of it was that every two to three months I would receive a letter from public health telling me they need a screening, they need a screening, they need a screening until I did my screening and it came back saying I was clean. […] I was, like, worried. […] …it’s kind of annoying, I must say. […] …oh my god, don’t they understand you cannot do it at the moment? Lord, give them something else to think about! They on your back like…fleas on a dog. You know how fleas come to a dog, they doesn’t want to leave? Immigration is on you like that until they make sure you clear. It’s annoying! Mercy! It’s annoying.

(Stacey, Overseas PR Applicant, old TB)

Despite having notified public health officials, Stacey was continually mailed IMS reminder letters urging her to complete the surveillance process. Not only are such reminders confusing for IMS clients as they contradict medical advice, but the constant reminder of being monitored by officials perpetuates fear and anxiety for newcomers in these situations.

4.6.1.3 Barriers: Paying for TB Medical Assessment

In general, while some participants were so relieved at having been approved for immigration that they were happy and willing to comply with any requirement, including IMS, several participants expressed frustration at having to repeat the exact same medical procedures shortly after arrival in Canada, especially since they just completed this same process back home.
…CIC told me that “You need to do [medical surveillance]”. So, it was a lengthy procedure back in my country. So I did all those things, but again I have to do it all over again in this country. So it was big hectic, because I […] have never been affected by [active] TB. I felt like all those things just took my money as well as my time. […] Those hospitals [back in my country] are certified by CIC, so their decision should be the last decision. Why they need --? Like, again I have to come over here; again I need to, like, spend money; again I have to do all the things which I did in my country. […] [It] doesn’t make any sense doing all the things, like, all over again. […] …going to do the sputum, and again going through x-rays and blood test, like, it’s just […] a waste of time, you know? (Sunny, International Student, LTBI[?])

So, when I got here [IMS was] another bit of a hassle for me because I had to, like, start from scratch, right? I have to find a new job, […] a place to stay -- I mean, I have a place to stay but of course, you know, figure things out. So, it’s been…really taking some of my time; like, when I’m supposed to be out there looking for work, I have to, like, comply with these immigration requirements – and, of course I don’t have any choice, right? Like, I’ve got my hands tied… […] Everything has always been repetitive. […]…it’s pretty much very…redundant. See, I’ve done the test a couple of times back home, and then I have to redo all the tests here? […] …as I told you, it’s been a bit of a hassle for somebody who’s migrating to another country who wants to start --, who wants to earn a living. […] And, you know, it’s not that easy to go off work, but of course we have no choice since we’re immigrants and stuff like that…

(Memphis, Overseas PR Applicant, LTBI)

The perceived redundancy of all medical tests and procedures as part of IMS was considered by newcomer to be not only a waste of time and money, but also reportedly interfered with their day-to-day life this early in their settlement period. For others, especially temporary residents with limited health insurance, not being fully aware of what the IMS process entails in terms of medical tests etc. makes it impossible for applicants to plan ahead and adequately prepare for medical surveillance, both mentally and financially.

I used to have my medical card, but those guys told me that “We won’t cover those things because you carried this-- this procedure was recommended [to] you by the CIC and you came affected by TB to Canada. […] …like, you were already affected by it in [your country], so we won’t cover those expenses.” So, I have to pay by myself – like, from my pocket. […] I’m not earning and I can’t spend, like, $300-400 – [it’s] a big amount for me because […] I get $600 GIC, so it will affect my budget. So, it was not easy.

(Sunny, International Student, LTBI[?])
Despite having private health insurance, coverage for procedures and tests required as part of IMS may be refused, unbeknownst to applicants, if TB is framed as a pre-existing condition or an immigration requirement. As a result, newcomers may be faced with the difficult choice of having to either accrue debt, spend a large proportion of their savings or income on medical tests in compliance with IMS, or be forced to disobey CIC’s instructions simply because they cannot afford to do otherwise if they are unaware of the TB-UP program.

4.6.1.4 Facilitators

In light of the aforementioned difficulties experienced by participants in this study, three factors were found to facilitate IMS at this stage. First, it was helpful to have family already living in Canada who could contact public health and learn about the details of IMS prior to the applicant’s arrival (Figure 5.2). Understanding the IMS process ahead of time would enable the applicant (and their family) to better prepare financially and logistically, and would provide some peace of mind.

Second, those participants who underwent their medical assessments at community health centres were more fortunate than those attending walk-in clinics. Because these clinics are tailored to providing care to new immigrants, uninsured patients are able to access medical care at no cost (Figure 5.2). Moreover, because TB is more prevalent among immigrant populations in Canada, clinic staff at community health centres not only has more clinical experience with TB, but also is generally better prepared to address various health needs of newcomers.

Lastly, IMS clients considered to have more “complex” cases of TB ironically face the fewest challenges during IMS. Given that these newcomers complete their initial IMS medical assessments at a public health clinic and, as a result, are referred to TB specialists directly, they are less likely to encounter some of the problems mentioned above, such as various clinical and bureaucratic errors, incurring unnecessary medical costs, redundancies of medical tests, and delays (Figure 5.2).

4.6.2 Step 6C: IMS Medical Assessment with TB Specialist

The results of the medical assessment performed by primary care physicians of newcomers undergoing IMS are submitted to public health officials. In more complex cases, or if any
concerns remain after the initial assessment, the physician, public health officials, or both (the physician in consultation with public health) refer the medical surveillance client to a TB specialist for further investigation (Rea, personal communication, Feb. 2017). While the objectives of this process are slightly different, the procedures and diagnostics involved are almost identical to those outlined in the TB furtherance process (Step 2C). The TB specialists perform a chest x-ray and collect sputum to test for active TB. If active TB is diagnosed, the patient must complete treatment; if active TB is ruled out, however, identification and treatment of LTBI are often pursued as part of IMS given that newcomers are considered to be “at highest risk of progression to active TB” (OMHLTC, 2008, p. 3). While a focus on diagnosing and treating LTBI is part of the Ontario TB Prevention and Control Program, it is neither a necessary condition of landing as per CIC nor a requirement of IMS; a client is thus discharged from the medical surveillance program once active TB is ruled out (or cured). If LTBI is diagnosed (or confirmed) in the context of IMS, however, prophylactic treatment is presented as an option for newcomers. Those who decline prophylaxis are “educated” about the signs and symptoms of active TB and are urged to seek care if these develop in the future (OMHLTC, 2008). In section 5 of this chapter, I describe the experiences of those participants who accepted prophylaxis.

4.6.2.1 Barriers: Repeated Testing & Awaiting Results

Participants described several challenges at this stage of the IMS process, the first pertaining to delays. Wait times for a specialist consultation vary depending on the urgency of the individual case. While some participants with more complex cases were directly referred to a TB clinic (i.e. Andrew) as part of their IMS process, most had to complete one or more rounds of medical assessments in primary care practice before the referral was made. Moreover, after it was decided that a specialist consultation was necessary, TB clinic appointment wait times took several months, once again delaying time to diagnosis, prolonging the IMS process, and perpetuating the fear, anxiety, and stigma experienced by participants (Figure 5.2).

The second challenge was encountered at the TB clinic and stemmed from a conflict between clinic procedures and newcomers’ expectations around TB screening and testing in the context of the entire Migratory Pathway. Each clinic structures patient visits according to national and institutional protocols which determine both the types and the order of tests and procedures performed during each appointment; these are standardized and apply to all patients.
indiscriminately. Participants took issue with having to repeat diagnostic tests performed at this stage in their Migratory Pathway. Having already been subjected to a multitude of x-rays and possibly sputum collection, participants expressed not only frustration at what they erroneously perceived to be unnecessary redundant testing, but also fear of health risks associated with these tests. After having to undergo countless x-rays over the course of her life (including during the diagnosis, treatment, and follow-up of two cases of active TB, as part of IME and TB furtherance, and IMS medical assessment in primary care practice), Awngshayi was concerned about the effects of repeated radiation exposure. During her first appointment at the TB clinic, Awngshayi questioned the need to repeat the chest x-ray and instead suggested to provide clinicians with a copy of her most recent radiograph, which was ordered by her family doctor. When she initially refused the test, instead of trying to determine the cause of her concern, Awngshayi was given an ultimatum by the clinic staff: “Well, our doctor is not gonna to see you if you don’t take a x-ray”. She further described her experience as follows:

[At the TB clinic]…they don’t ask anything. […] I talked to the…like, a doctor…but this [other staff], they don’t ask-- they don’t even try to-- they’re not gonna to listen what you trying to say, you know? […] They’re so busy. They were say you “blah blah blah blah, you have to do this”, and left. They would not even stand up to listen to what you’re trying to ask, you know? They’re not listening. […] I have to listen to her! […] [If you want something], [y]ou have to really push harder. Otherwise…you are just…you're nobody. You’re just a number…That’s like a becoming robot, you know? The way they approached it. That’s why I hate procedure…So…I don’t want to consider now myself is a tuberculosis – is so disadvantage. People push you…you cannot do anything. […] I wish that they care more about the patient than the procedure that they have to follow. […] Fine line, you know? Follow the procedure, explain them…but just listen. […] People don’t want to listen from the patient’s side; they want patient to listen what they said. But for me is strange thing that is the patient the one who gonna to take all the stuff, not them… (Awngshayi, Government Sponsored Refugee, old TB)

In the end, Awngshayi felt that as someone suspected of having TB, she did not have much agency in relation to health care staff. As a patient and an IMS client she felt victimized by both the clinic procedures and the IMS process overall.

Third, several participants reported being asked to provide TB specialists with copies of previous x-rays and other diagnostic images or medical files in an effort to help establish a health history and assist in making a more accurate diagnosis. Because it is not typical for patients to request
and retain copies of their medical files, most study participants did not have these readily available. While from a clinical standpoint, access to previous chest x-rays etc. may help to establish stability of the abnormal pulmonary lesion sooner thus shortening the time one remains under medical surveillance, on the other hand, such a request may pose a logistical challenge for newcomers, especially if the tests in question were performed outside of Canada. For some individuals, like Zara, it may be impossible to obtain these files if they have already been submitted to CIC as part of the IME, for example. Although others may be able to obtain their old medical images, this may require some effort on their part to retrieve them from their home countries. David described how he acquired his old medical files:

…there was a two months appointment […] after [the first], and [the TB clinic staff] hope that they can see the CT image that I got [back home]. Then one of my friend came back to [my home country] in the Christmas holiday and my mother send her my CT picture, and then she help me took from [home country]. (David, International Student, no TB)

In this study, Zara was the only participant who perceived the retrieval of her medical files as problematic. In the context of immigration, however, given some patients’ perspectives about their agency (or lack thereof, as per Awngshayi), the fear about the implications of noncompliance with TB specialists’ request in the context of IMS, as well as the perceived effects of noncompliance on their immigration status, such a request may be misinterpreted as a necessary requirement rather than a choice. While having a copy of their medical files might be useful to health care providers and may assist TB specialists in establishing an accurate diagnosis sooner (with potential positive effects for newcomers), this information is not communicated to applicants at the start of the application process; CIC only recommends that applicants provide PPs with any medical files for the IME who, as I learned from Zara’s account, take possession of these files and submit them to CIC. This situation highlights an interesting paradox: although previous health records may be a facilitator at the TB furtherance/IMS stage in helping to establish a diagnosis, these records are not sufficient on their own and may be rejected by TB specialists as new patients are required to repeat chest radiographs. This can cause additional confusion and frustration for newcomers undergoing this process.

Fourth, attending TB clinic appointments was perceived as a challenge as it affected day-to-day life of not only IMS clients, but also their families. While this is not a unique experience to
anyone who needs to access health services, this was particularly challenging in the context of immigration and settlement as newcomers had other priorities associated with the early settlement period in Canada such as finding a job or attending work or school. Furthermore, those who were already working may find it difficult to take time off from work to attend doctors’ appointments as new employees. Many participants also had to be accompanied by family members who were a source of emotional support, helped them navigate around an unknown city, and in some cases served as translators during their TB clinic visits. Even those who attended alone required help from spouses or other family members. For example, Zara had to make arrangements with her husband to take time off work and stay home with their baby so that she could attend the TB clinic:

...because of the baby, we have to, you know, make an arrangement for [my husband] to sit [at home]. Because, like I said, there might be other patients who are visiting the same doctor’s office who might have [active TB] infection, so I try not to take my baby to the hospital. I mean there’s no point taking babies to the hospital unless it is for them. So, I just make an arrangement, I ask my husband to sit and, you know, babysit [our] baby at the home, and I go alone. (Zara, Overseas TR & In-Canada PR Applicant, LTBI[?])

In order to comply with IMS, clients are required to schedule their lives around clinic appointments; in some cases, they have to request their family members to do the same. As a result, attending TB clinic appointments not only takes time and focus away from other priorities, but also carries a direct (cost of travel) and indirect (missing work) financial cost for both IMS clients and their families (Figure 5.2).

4.6.2.2 Facilitators

Despite these challenges, three things served as facilitators for participants at this stage of the IMS process (Figure 5.2). First, despite the inconvenience and cost of attending TB clinic appointments, participants were grateful for the help and support of family. Second, an early and expedited referral to a TB specialist clinic within the first three months after arriving in Canada was helpful for newcomers; not only did this shorten the length of the overall IMS process by bypassing assessments in primary care, but it also prevented unnecessary costs of TB-related medical tests for uninsured newcomers as these patients were registered for the TB-UP program. While provision of coverage under the TB-UP program is not restricted to specialist TB clinics,
health care providers working specifically in TB appear to have more familiarity with this program than primary care physicians. Moreover, because patients must be registered for the TB-UP program prior to receiving services (Toronto Public Health, 2017a), TB clinic staff are able to arrange the necessary paperwork ahead of time as they have access to more information about incoming IMS clients (including whether or not they have health insurance) prior to the appointment.

Third, although participant experiences at the TB clinics varied with some perceiving their interactions negatively (i.e. Awngshayi), the majority of participants in this study described their encounters with TB clinic staff as generally positive. Most participants reported that the care they received from specialist clinics was better than any TB-related care they have received elsewhere during the entire immigration and IMS process. Clinicians readily informed patients about the rationale and procedures behind medical surveillance, the implications of test results for CIC as well as their own health, and made the patients feel comfortable and genuinely cared for. Moreover, many of the staff offered to continue providing medical care to participants in the future (if necessary) and welcomed future contact from newcomers if they required any additional documentation or proof of compliance with IMS to CIC, public health, or any other authorities. This patient-centred approach was paramount in dispelling some of the stigma participants had internalized and helped to relieve some of the anxieties surrounding medical surveillance for newcomers.

### 4.6.3 Step 6D: IMS Medical Clearance

Medical clearance marks the end of both the immigration and medical surveillance processes for all PR applicants (although those living in Canada as temporary residents will have to repeat the IME, and possibly the IMS process, when applying for permanent residency in the future – a point discussed in more detail later in this chapter). Similarly, as with the IME, obtaining medical clearance for IMS is a multi-step process involving TB specialists, public health officials, and CIC. First, the TB physician (or primary care physician) provides verbal medical clearance to the patient once active TB is ruled out. Next, this information must be communicated to public health officials and supported with appropriate documentation. Once this is received, Public Health sends out a letter to the client officially discharging them from medical surveillance and notifying them that they have fulfilled the condition placed on their
immigration status. Lastly, CIC must be notified of the client’s completion of, and compliance with, IMS in order to remove this condition from their immigration file. Although it is unclear whether the Public Health unit or the applicant must contact CIC in this regard (CIC, 2014b; Toronto Public Health, 2017b), it is nevertheless the newcomer’s responsibility to ensure that appropriate documentation is received by CIC.

While none of the participants in this study cited any specific barriers to obtaining final medical clearance or experienced challenges at this stage, they did mention a number of unexpected effects. Despite having undergone such a lengthy screening and surveillance process for TB often involving repetitive testing and medical assessments, Zara was never given a clear diagnosis and was still confused about her health status:

…I don’t know whether I had latent TB, inactive TB, yes or no, I don’t know. So […] if in the course of the entire medical surveillance that they talk about, if they could tell -- you know? […] So I don’t know […] they have kept it like a, you know, grey area -- "if you develop […] symptoms of all these six, seven things that [we] have mentioned, report to us; otherwise you’re good to, you know, continue with your life - you’re discharged”. So, I don’t know whether I had latent TB or not.

(Zara, Overseas TR & In-Canada PR Applicant, LTBI[?])

Moreover, Zara’s concern over a lack of clear diagnosis was compounded by having to submit all of her medical files to CIC, which documented her extensive and complicated medical history. She perceived this to be potentially problematic for future migration:

…if I have to, like, move to another country, now my x-rays are not there with me…Now that I know the importance of all your old medical files, especially with a condition like this where my doctor had told me that a chest x-ray would look the same for your lifetime. So, I don’t know if I apply for a, you know, to move to another country and if I have to go through a similar examination, how would I prove what happened in 2008? Where are my x-rays? I don’t have anything as yet. And they haven’t given me a clearance as in “I didn’t had TB”. So it’s still doubtful, right? Maybe I was infected. I don’t need a treatment but they haven’t given me, saying, you know, “You didn’t had TB”. That has not been ruled out yet. And I don’t have anything else to prove […] If I have to move somewhere else and if I have to go through the stringent medical process, I am kind of worried because I don’t have the reports.

(Zara, Overseas TR & In-Canada PR Applicant, LTBI[?])
Similarly, having completed the IMS process, a few of the participants were not convinced that they truly received “clearance” and were worried that they would have to undergo medical surveillance again in the future. This was conveyed by Memphis who, after stating “I’m so relieved that I was cleared out of the TB” looked to me for confirmation: “I’m right–I’m right, right?! I-I’m cleared up!” adding, after a pause: “…at least I got that off my plate…for a little bit” (Memphis, Overseas PR Applicant, LTBI). This implies that Memphis was not completely certain that this process had reached its end for her. Zara and Stacey shared similar skepticism about the finality of medical surveillance:

I am assuming, if I change anything with my status in Canada, I will have to go through the same things again…And the clearance – I hope [it] holds value. I hope -- probably I will not be asked to go through medical surveillance again. Right? (Zara, In-Canada PR Applicant, LTBI[?])

I just hope they don’t come back behind me and tell – after a few months – and tell me, “You have to go testing again.” … I did it twice. I did it back home, and I had to do – I was clear back home, I still had to be cleared in Canada. So, basically you never know if [they] also have time to make sure you’re clear again. They might have a third time … So, I know. When that kind of atmosphere [being exposed to second hand smoke in public] … I will get called again; just have to brace myself and make sure I stay healthy so that they will not call me, not maybe until, ah, they have to again. I don’t want to be called again. (Stacey, Overseas PR Applicant, old TB)

These examples demonstrate the degree of doubt and perceived persecution that arose as a result of the medical surveillance process for some newcomers involved in this study; they also highlight the potential for these effects to persist long after the immigration process and medical surveillance have ended. Lastly, it also raises questions about the effects of this process on new immigrants in the context of global migration.

5 Additional Considerations

The 6 steps described above are mandatory aspects of newcomers’ Migratory Pathways based on Canadian policies and procedures for immigration, clinical practice, and public health. The descriptions and effects provided for each step illustrate some of the ways in which these policies
translate into the material and social reality of people’s lives. While these steps provide an explanation of the Migratory Pathway as depicted in this study from beginning to end, they imply a linear progression through the process which is not only misleading, but also omits two important considerations. First, while prophylactic treatment is not mandatory for newcomers, because LTBI diagnosis may result from IME or IMS TB screening, the treatment of LTBI is related to – yet exists outside of – the immigration and IMS processes. As such, its effects on newcomers as well as its relation to the Migratory Pathway must be examined. And second, the cumulative effects of overlapping Migratory Pathways present a unique set of challenges for newcomers which must be considered and explained separately. The last two sections of this chapter address these two issues.

5.1 LTBI Diagnosis & Prophylactic Treatment

LTBI may be detected in newcomers either during the IME or IMS. While all cases of confirmed LTBI are reported to Public Health in Canada (either directly for In-Canada PR Applicants or indirectly for Overseas Applicants through IMS referral), CIC does not require newcomers to undergo treatment for latent infection as a condition of landing or immigration status. In other words, while the diagnosis of LTBI may occur in the context of the immigration process or may directly result from immigration TB screening and surveillance, prophylactic treatment is presented as an option in the interest of the individual’s own health. Furthermore, although LTBI treatment is separated from immigration in policy and legislation, the two cannot be truly disassociated from each other; given the extensive duration of the treatment regimen (approximately 9 months), this is particularly true if newcomers begin prophylaxis before the immigration process has ended. It is therefore useful to examine the ways in which decisions around prophylactic treatment are influenced by, and how they may in turn affect the immigration and settlement process for newcomers to Canada.

Out of four participants in this study with LTBI confirmed during the IMS stage, only two chose to treat the condition (Fiona and Eve; Memphis and Angela declined). Moreover, many others undergoing TB testing and surveillance were told at one point or another that they may have LTBI, prompting them to consider the possibility of treatment pending diagnosis. As such, conversations around LTBI and prophylaxis with research participants revealed some interesting insights.
First, some participants were more open to the idea of treating LTBI than others. Several individuals expressed the immigration TB screening process as beneficial to their own health because it revealed a latent and potentially dangerous condition which they may have previously been unaware of. To that point, they viewed prophylaxis as an opportunity to take charge of their own health and eliminate the potential future threat of developing active TB.

...ever since they told me it was treatable, I'm like ‘okay, yeah, I'm just going to treat it.’ I just want to be done with it. [...] I'd rather do it right away so then in nine months I'm free, you know? I don't have to be worried about it anymore. I can just...go on with my life. [...] I don't see why people would wait or wonder, ‘Oh no, I don't want to get treated --‘ why? I mean, you can just get treated right away and then it's gone, for-ever!...It's-it's [a] very easy decision to make. At least for me. (Eve, In-Canada PR Applicant, LTBI)

Others, like Jane, believed that the risk of adverse effects of chemoprophylaxis outweigh the benefits of potentially curing latent TB. In addition to widely shared concerns about medication costs, this range of personal attitudes towards health and illness is expected to influence treatment decision-making in any circumstances. In this study, however, newcomers had to consider many other factors related to immigration and settlement before making their decision. First, because attending appointments over the course of preventative treatment is undeniably a time commitment given its strict and lengthy regimen involving regular follow-up clinic visits, the time requirement as well as the psychological (i.e. self-discipline and self-monitoring to ensure that medication is taken on time) and practical burden involved in treating LTBI was a disincentive for some participants; concerns about school attendance (particularly for international students), as well as searching for / attending work took precedence during the initial settlement period.

Like, so [prophylactic treatment is] a commitment. Like, I have committed my time and my efforts in something [already], like studies. So again, I’ll be having a second commitment, like, everyday taking the medicines. If I skip taking medicine then that doesn’t make any sense because it’s a nine month procedure. [...] So, right now? I think I’m more concerned about my studies rather than this one. So, once I’m done with this thing -- like, my last semester is going now -- once I’m done with my studies then I will-surely, I will look forward to it. [...] [B]ecause every month I have to come over here – I have to miss my classes sometimes to get to hospital. So, right now it’s very difficult to manage it. (Sunny, International Student, LTBI[?])
…when I get back [to Canada], I’m gonna have to get my life back on track. Like, my priorities are completely other ones, you know? It’s not to find out if I really, really, really [have LTBI], you know? Like, that’s not my priority.

(Jane, “Removed” In-Canada PR Applicant, LTBI[?])

…I’m working two jobs and, you know, got pretty much a lot on my plate right now.

(Memphis, Overseas PR Applicant, LTBI)

Second, some participants cited having to attend to other more pertinent health issues that have either emerged during the immigration and settlement process, or have otherwise been ignored during this time. For instance, in addition to LTBI, Memphis was diagnosed with kidney stones and recurring endometriosis shortly after arriving in Canada. Given that she had three significant health issues to deal with simultaneously, she had to make a choice as to which would take priority:

…turns out I have kidney stones. […] I was actually supposed to have surgery this summer. But, turns out I also have this […] endometriosis […] [which] I found out about […] while waiting for the results of the sputum test. […] So, they didn’t thought, like, which ones to prioritize. […] [A]t this exact same moment is when they told me that ‘okay, you’re clear for immigration, you don’t have TB, but there is a sleeping TB that’s waiting to happen, blah, blah, whatnot -- ‘…I don’t feel any different right now except for the fact that I know that I have another thing going wrong with my body, like, with the ovary. So, pretty much my mindset right now is leaning towards prioritizing the other rather than the…the TB… (Memphis, Overseas PR Applicant, LTBI)

Jane, on the other hand, was living in Canada for a significant period of time without health insurance even prior to submitting her PR application. Having refrained from seeking medical care during that time, pursuing a definitive LTBI diagnosis and potential treatment were not of primary concern to her once her application was approved:

I have other medical stuff to look at. I just haven’t…again, my priorities have been others because I didn’t have my health insurance for so long so…I have other stuff to look at. (Jane, “Removed” In-Canada PR Applicant, LTBI[?])

Third, in the context of the immigration application process, the point at which LTBI and prophylaxis are discussed with patients may interfere with their ability to make an informed
decision about LTBI treatment. For In-Canada PR applicants, these conversations initially took place with TB specialists during the IME Furtherance process. During these encounters, however, participants also learned the details about what the TB furtherance process entails, including specific procedures and timelines to completion, which often came as a shock to applicants. At that point, participants became preoccupied with the implications of further delays on their immigration application and described being unwilling to listen or unable to process any other information discussed with clinicians.

I was kind of, like, ‘I don’t care. I don’t really-‘, you know? ‘Sure, tell me what you have to tell me but it doesn’t matter to me! Just do what you have to do’. […] Like I said, after [the TB specialist] said, ‘We’re gonna have to do this thing, that’s gonna take two months’, my mind was already, like, ‘that means I’m gonna have to do dah, dah, dah, dah,’ you know, as he was talking. So, obviously I was listening to him but not processing it as much ‘cause I clearly don’t remember [any information about LTBI testing]. (Jane, “Removed” In-Canada PR Applicant, LTBI[?])

…when I’m doing the test, I’m like ‘oh my god, it’s going to take two more months’ because I know exactly it’s the same test that I took already, and the nurses back at the doctor’s office told me it’s going to take two months, so I’m thin[king] when I’m doing the test I’m stressed, I’m anxious, and I’m, like, it’s going to take two more months so I have to wait more, and I’m already-- you know, my brain is working, um…so that wasn’t great. (Eve, In-Canada PR Applicant, LTBI)

Evidently, these results suggest that for immigration applicants the timely completion of the CIC application may be a priority over optional treatment of an asymptomatic condition.

Lastly, despite not being mandated by CIC, newcomers’ misperceptions about the implications of LTBI treatment (both accepting and rejecting it) for their immigration status or their immigration application process may influence their decision around prophylaxis. For Sunny, despite his positive attitude about prophylactic treatment as a health benefit, the fear of potentially prolonging the medical surveillance process and jeopardizing his immigration status was one of the factors that deterred him from further investigating whether or not he had LTBI.

I just want, like, from CIC guys, that my case has been closed. Like, I need not to do anything and, like, […] it’s been done. Like, they close my file, and then I’ll think about it – whether I need to do […] take the medication or not. But…I’ll take some time to take that decision. First of all I just need to know what the decision of the CIC regarding my
disease. If they tell me that everything is good, everything is fine, then I’ll think about it.
(Sunny, International Student, LTBI[?])

In contrast, when asked about her decision to begin prophylaxis, Fiona explained that she did so out of fear of being denied permanent residency in the future.

…the doctor said it’s up to me if I’m willing to take the medication or not. Then [my boyfriend] said, ‘You need to take the medication because in the future, if you have a TB, the immigration—‘…maybe…because they take […] for my immigration, for my papers, you know? If I have a TB, maybe the immigration say […] ‘Okay, stop! I don’t give you the PR; you need to cure first your tuberculosis,’ or something like that. So my boyfriend said, ‘You need to do [prophylaxis], even if it’s not active, you need to drink the medication.’…So, that why me, before I ask my boyfriend, […] I decided already that I need to take my medication.” (Fiona, Temporary Foreign Worker, LTBI)

Much like the effects of IMS itself, these responses highlight not only the lasting effects that policies can have on newcomers long after the immigration process has ended, but also the far-reach they have for the conduct of newcomers on practices and behaviours beyond what is considered a “mandatory” part of immigration. The fear generated around an applicant’s admissibility based on medical criteria can influence newcomers’ decisions about their health long after arrival in Canada.

5.2 Overlap of Migratory Pathways

Obtaining Medical Clearance for IMS completes the Migratory Pathway for applicants. As already mentioned, however, applicants may undergo more than one pathway before becoming Canadian citizens; this is common for immigrants who enter and live in Canada as temporary residents and eventually apply for permanent residency. Pathways may either run sequentially (where the TR pathway finishes completely before the application process for PR begins) or, more typically, may run concurrently (the individual may still be completing a certain step of the TR pathway at the time of initiating their PR application process in Canada), meaning that applicants may be simultaneously completing any number of stages in the immigration process from either pathway. In addition to the Migratory Pathways, individuals may be undergoing prophylactic treatment for LTBI at the same time. As a result, newcomers simultaneously
undergoing more than one process (TR application renewal, new immigration application or IMS) face challenges not only because they must manage two (or three, if on prophylaxis) separate pathways at various stages, but also because any problems encountered in one pathway may interfere with the immigration process of the second pathway in unexpected ways.

Three participants in this study (Jane, Eve and Zara) had to simultaneously complete two Migratory Pathways while in Canada. Both Eve and Jane, who lived in Canada as temporary residents for several years before applying for permanent residency, were required to continually renew their visas and work permits (as well as their passports) before the end of each renewal period to maintain their legal status (Figure 5.3). For Eve, these procedures significantly affected her experience of day-to-day life:

…it’s just so many visas, so many forms, every year I need to fill in new form[s], every year I need to fill in, you know, just paperwork for a new visa and...I cannot even enjoy the fact that I have a current visa because I always need to think about another visa. Uh, it’s just very annoying. It’s just so many things I need to think about. …And it’s really what is right now…kind of guiding me in my day-to-day life because I cannot work wherever I want right now because I have a closed work visa with my current job, so even if I wasn’t satisfied I couldn’t even change it because I need to stay…in my current job. So it makes it way more complicated…and a bit annoying, I must say.

(Eve, In-Canada PR Applicant, LTBI)

While Eve felt that her life as a temporary resident in Canada was constrained by both a seemingly endless bureaucratic cycle as well as the type of work permit, she did not seem to face any particular difficulties managing both her TR and PR application processes (at the time of the interview Eve had just agreed to start prophylaxis, so it is unknown how the treatment regimen further affected her day-to-day life).

In contrast, Jane encountered challenges not only as a result of having to renew expiring documents (such as OHIP and her passport), but also by having to simultaneously apply for both TR renewal and PR application. As a temporary foreign worker, Jane was eligible for OHIP coverage. However, given the nature of her work (contract-based), she had difficulty proving that she satisfied one of the qualifying criteria – being employed on a full-time basis with one employer for minimum of 6 months (OMHLTC, 2012). While Jane was initially able to obtain health coverage with the assistance of a government employee, she was unable to provide the
required documentation a second time and, as a result, could not renew her OHIP. In effect, despite living and working full-time in Ontario for several years, Jane did not have appropriate health coverage and had no choice but to leave several health issues unaddressed.

A second and more serious challenge arose for Jane a year after she had submitted her PR application. She inquired with CIC about the need to renew her temporary work permit given that her PR application was already being processed and, in error, was advised by government officials not to renew it. Eventually, Jane was given correct information and was notified that by allowing her work permit to expire she was not only working illegally in Canada, but that she had also lost her legal status as a temporary resident. She was instructed to reapply for the renewal of her expired documents within 90 days (at an extra cost) all the while having to undergo her IME and TB Furtherance for her PR application as well as renewing her passport (which, coincidentally, was expiring around the same time). After the 90 days, CIC returned Jane’s work permit renewal application to her stating that it was the wrong application and, given that she had “fallen out of status”, she was also sent a Departure Order to leave Canada within 30 days (Figure 5.3). As her TB furtherance was still ongoing, Jane rushed to complete the process before having to return to her home country where she awaited the verdict of her PR application. Being forced to leave the country was not just a big financial burden (e.g. having to cover the cost of airfare), but generally had significant financial and psychological effects on Jane:

I think the way I am fits better in Canada… […] I feel like it’s the type of community that I want to live in. […] …I had my whole life [in my home country] […] [but] I was living a life that I didn’t really want to live. […] So then when I left and I went to Canada and I saw, you know, “this is what I want”, and I started working in my field, and I’m like, “these are the people I want to hang out with” – that felt a lot more like home. Then coming back here! […] I feel zero need to see [any of my old friends] because I feel I have nothing in common with them anymore. […] And there’s a big difference too – I’ve kind of also fallen behind, ‘cause all my friends are married with children now and I’m still…barely working! I’ve only started working professionally…since 2011, so it’s like, I’ve kind of fallen behind. And now even more ‘cause I’m not even there [in Canada]…and I had a job offer waiting for me from [a very prestigious organization] that I had to [turn down] and be like, “Sorry, I’m in [home country]”. So…I wasn’t able to do that… […] But this is not what I expected. I never thought I’d have to, like, get kicked out, basically, out of Canada. (Jane, “Removed” In-Canada PR Applicant, LTBI[?])
Having already settled and made her new life in Canada, going back to her country of origin meant that Jane had to uproot her life, leaving her boyfriend and friends behind and missing out on a big career opportunity. As a result, Jane found herself in a state of stress, anger, and disbelief. While it cannot be stated with certainty, there is a possibility that had Jane not been required to undergo TB furtherance (which unexpectedly delayed her PR application) at a time when her temporary residency expired, her PR application may have been approved by CIC before her Removal Order took effect.

Zara was also faced with having to simultaneously manage the requirements of two immigration applications. Shortly after arriving in Canada as a temporary resident, Zara submitted her PR application. In one way, the overlap of pathways was helpful: Given that she was under post-landing medical surveillance at the time of her IME for the PR Application, Zara was exempt from having to undergo TB Furtherance in Canada (Figure 5.3). However, after completing IMS as part of her temporary residency (which lasted one year and 8 months), once her PR application was approved just a few weeks later, Zara was given a referral to undergo IMS again, this time as a condition of her permanent residency in Canada. Shortly after contacting her public health nurse, Zara was able to obtain her second IMS clearance luckily without having to repeat the process (Figure 5.3). In Zara’s case, the overlap of the IMS and IME processes shortened the time required to complete the IME for her PR Application by at least 2 months. Moreover, while she was spared from having to repeat the IMS process a second time, Zara was still required to obtain and provide documentation of compliance with CIC’s mandate to “complete” IMS again.

The results pertaining to the overlap of Migratory Pathways highlight an important issue: while an applicant may undergo more than one immigration application process (either sequentially or concurrently), their CIC files are not linked to each other based on the applicant’s identity. In other words, CIC does not focus on the applicant as an individual (e.g. one individual with several applications), but rather focuses on each application in isolation. Under these conditions, it is possible for various challenges to arise for applicants such as loss of status and unnecessary duplication of medical tests, assessments, and screening, with implications such as additional costs, loss of time, and potentially major disruption to immigrants’ lives.

To that last point, these results also shed light on the concept of settlement and where / when it begins along the Migratory Pathway. While ‘settlement’ is a very individual process tied to
personal motivations behind migration, participants’ responses indicate that settlement for newcomers begins at the moment of arrival in Canada before they have completed IMS and obtained medical clearance confirming their immigration status regardless of whether they are here as temporary or permanent residents. It is therefore important to note that a disconnect exists between the settlement process of people and their official CIC document approval. As such, until immigrants achieve PR status, as temporary residents, newcomers’ lives in Canada are shrouded in uncertainty; even though they may have already ‘settled’ and adjusted to life in Canada, they are at risk of losing their official status as residents if their PR applications are rejected (or, as in Jane’s case, they unintentionally “fall out of status”), which potentially carries serious material, social, and psychosocial consequences. To use John’s metaphor, they may be building a shelter on sand which can be easily and unexpectedly wiped away.

6 Chapter Summary

In this chapter, I described the various steps of participants’ Migratory Pathways and explained how the migratory journey is shaped by Canadian policies and guidelines around TB and immigration, clinical, medical and public health practices. Based on participants’ accounts, many faced unexpected barriers and challenges (with some facilitators) during the immigration process causing them to deviate from the expected official Migratory Pathway, which carried various psychosocial, material and social effects on their lives, both before and after arrival in Canada. While this first part of the study results illustrates what the immigration process entails as well as its various effects on newcomers, in the next section I explore the ways in which power was negotiated by participants at the different stages along the Migratory Pathway.
Chapter 6
Results II: Negotiating Power Along the Migratory Pathway

[An analysis of power relations] … consists of taking the forms of resistance against different forms of power as a starting point. … [I]t consists of using this resistance as a chemical catalyst so as to bring to light power relations, locate their position, and find out their point of application and the methods used. Rather than analyzing power from the point of view of its internal rationality, it consists of analyzing power relations through the antagonism of strategies. (Foucault, 1982, p. 211)

1 Introduction

In the previous chapter, I presented the first part of the results where I reconstructed participants’ migration journeys as Migratory Pathways. These pathways depict the necessary steps that participants in this study had to complete, both in Canada and abroad, as part of the immigration and settlement process (which includes medical screening and surveillance for TB). The previous section provides a more procedural analysis of the immigration and medical surveillance processes which lays the necessary groundwork for contextualizing the remainder of the results. Through discourse analysis, the next two Results chapters aim to reveal relational dimensions of the immigration and settlement and medical surveillance processes by closely examining the individual practices of participants and interpersonal encounters that take place at various stages along the Migratory Pathways. Using a governmentality framework, these two chapters will answer the second research question:

How do immigrants undergoing TB surveillance negotiate power throughout the different stages of the immigration and settlement process: a) in international (pre-migration) and national (post-migration) settings? and b) during the Canadian TB clinic encounters?

The first part of this question, part A, is addressed in this chapter. In the next chapter, Chapter 7, I present findings specific to the Canadian TB Clinic to address part B of the research question.
I organize the presentation of results following the structure of the research question as well as the established chronology of steps along the Migratory Pathways. Drawing predominantly from interview data, this chapter centres on the Immigration Medical Exam (IME) (including TB Furtherance) and the subsequent referral for Immigration Medical Surveillance (IMS). Due to the heterogeneity of the study participants in terms of immigration class (temporary vs. permanent residents), the location where the immigration application was initiated ("In-Canada" vs. "Overseas"), as well as the nature of the IMS process (which involves encounters with public health officials and various healthcare providers after arrival in Canada), I analyze participants’ experiences in both national and international settings. Four participants (John, Jane, Margaret, and Eve) were referred to the Canadian TB clinic to complete their In-Canada IME, therefore observational data from their clinic encounters is also presented in this chapter as it pertains to the IME specifically.

Each section of this chapter begins with an explanation of the discursive elements of what happens to participants at the various stages of the immigration process (IME, TB Furtherance, referral to IMS, contact with Public Health, walk-in clinics, and IMS at the TB clinic). This is followed by the ways in which participants respond in each situation through active engagement by taking up, resisting, and negotiating power. While there are countless possibilities for the ways in which individuals may engage with experts along the Migratory Pathway, several dominant typologies emerged from the data; it is these typologies that are presented here and discussed in detail in the discussion chapter (Chapter 8). Before I turn to these results, however, I present a brief discursive conceptualization of the immigration and settlement and medical surveillance processes to contextualize the study findings.

2 Underlying Logics of Immigration, Public Health & Medicine

Immigration, Public Health, and Medicine, as disciplines or discursive domains, each form a distinct discursive field. A discursive field serves a specific function in constituting social agents, defining various obligations and responsibilities of each individual, and distributing these among the different categories of people encountered within the specific discursive field (Parton, 1999, p. 106). All social actors in each field function according to the underlying logic of each respective domain (Foucault, 1991b, p. 63). In this study, the ‘Immigration’ social actors are CIC
agents, Canada customs officers, visa application centre staff, CIC Medical Officers, etc. The Public Health actors are nurses, epidemiologists, medical officers of health, program supervisors etc. Lastly, administrative staff, nurses, physicians, etc. are the social actors encountered by participants within the domain of Medicine. While a discourse analysis of policy is not the focus of this study, I include a brief examination of the discursive formation of subjects (the study participants) in official documents (e.g. legislation, policy, and guidelines). Moreover, I describe the stated objectives of each of the 3 domains and the outlined professional responsibilities of these experts in relation to subjects as this allows for a better understanding of the power structures and underlying logics which shape the nature of encounters produced within each domain. This critical perspective helps to better understand the network of power that study participants – each with their own personal objectives – had to negotiate as they moved through the Migratory Pathway, particularly at sites where these discursive fields overlap.

2.1 The Logic of ‘Immigration’

Insofar as it relates to this study, the role of the Canadian immigration system is to monitor and systematically select individuals for entry to Canada as temporary or permanent residents. As with any selection system, there are various criteria which individuals are selected for as well as against. The objectives of the Canadian immigration program, as outlined in the Immigration and Refugee Protection Act (IRPA) (S.D. 2001, c. 27), include the selection of those candidates who are believed to “enrich and strengthen the social and cultural fabric of Canadian society” and “permit Canada to pursue the maximum social, cultural, and economic benefits” (3.1.a,b). Furthermore, the functional responsibility of the immigration program includes identification and refusal of entry of individuals perceived to pose a threat to public health and safety or a threat to the security of Canadians. An immigration applicant’s inadmissibility can result from a number of factors: criminality, violation of human rights, posing a “security risk”, direct or indirect “misrepresentation” on an immigration application, inability to financially support oneself, or a medical conditions deemed ‘dangerous’ or ‘burdensome’ (CIC, 2015b). Against this backdrop, it can be argued that the underlying logic of the immigration system is the pursuit of nation building as well as the ‘securitization’ of borders through border control practices (Horner et al., 2013). According to this logic, the preferred immigration candidate is discursively constructed as healthy, responsible, honest, and economically productive. Conversely, a “foreign national”
(IRPA, 2001) who is constructed as ‘dangerous’ (where the nature of the ‘danger’ is either criminal or contagion), burdensome (e.g. ‘pathological’), and / or dishonest is perceived as a threat to the Canadian social body. This distinction defines various types of foreign ‘others’, identifying some as a ‘threat’ and subsequently legitimizing the state’s role in protecting the collective identity and safety of Canadians.

### 2.2 The Logic of Public Health

The underlying principles of public health (specifically as it relates to the control and prevention of infectious diseases) share some similarities with the immigration system, particularly with regard to the protection of the Canadian social body. Unlike immigration, however, the nature of the threat of TB is constructed as pathological, locating it within Canadian society as opposed to outside of it. The objectives of public health in the control and management of TB are guided by epidemiological and biomedical principles which include identification and elimination of active infection, reduction of transmission, reduction of progression of LTBI to active TB, and prevention through health education and health promotion (OMHLTC, 2008, 2016, 2017). While the treatment of diseased bodies is underpinned by the logic of care for the individual, it is done so in the interest of the collective. This requires certain practices such as active surveillance and the collection of demographic information about individual ‘clients’ (with an emphasis on the country of origin) who pose a ‘threat’ to the social body (OMHLTC, 2008) as a means to identifying entire groups of people for large-scale management and interventions. Such an approach has two effects: it discursively constructs certain groups as a threat based on a number of shared characteristics, and it further legitimizes the need for targeted surveillance, screening, medical intervention, and bureaucratic management of individuals within “priority populations”.

It is important to point out, however, that the public health system has a responsibility to protect the safety and wellbeing of all Canadians, including those identified as a ‘risk’ or ‘threat’ to others. By providing necessary TB treatment indiscriminately to all individuals living in the community regardless of nationality, immigration status, or access to health insurance, the discursive ‘public’ in public health appears to refer to any person physically living in Canada.
2.3 The Logic of Medicine

Although legislation, regulations and guidelines that govern medical practice vary across jurisdictions and branches of medicine, all physicians are guided by the same ethical standards outlined in the Canadian Medical Association (CMA) “Code of Ethics” (CMA, 2004). The fundamental principles of medical practice in Canada include “compassion, beneficence, non-maleficence, respect for persons, justice and accountability” (CMA, 2004, p. 1). Physicians are first and foremost described as health care providers, and the doctor-patient relationship is considered to be “the foundation of the practice of medicine” (College of Physicians and Surgeons of Ontario [CPSO], 2007, p.5). A brief analysis of the CMA Code of Ethics supports this claim. Of all the responsibilities listed in the document, over half (57%) are explicitly related to the care for the patient, followed by a physician’s responsibilities to the medical profession (26%), and to maintaining the health and wellbeing of the community and society (11%). The remainder includes respect for human rights as well as responsibilities for the health and wellbeing of the self. Physicians are charged with a duty to advocate on behalf of their patients (CPSO, 2007), prioritize their patients’ needs, and ensure that they receive “optimal quality care” (CMA, 2015, p.1).

Based on a review of these documents, it is apparent that medical practice is guided first and foremost by the logic of care for the patients as an individual, with a strong focus on ensuring the patient’s health and wellbeing and respect for their values and agency (the secondary focus on continued professional development and lifelong learning demonstrates the grounding of medical practice as an exercise of scientific reason). While a definition is never provided, a ‘patient’ is discursively constructed as any person in need of medical care. Given the values and principles of the medical profession, it is assumed that the entitlement of an individual to receive such care should not be constrained by his or her ability to pay for medical service (CMA, 2004, p.2). As such, Canadian physicians have a professional and ethical responsibility to provide medical care to any individual encountered in their practice regardless of immigration status or access to health insurance.
2.4 Overlap of Discursive Fields & Competing Logics

The immigration and settlement process, with its reliance on medical examination of applicants, its focus on identifying communicable diseases, and the exclusion and management of diseased bodies, requires the intersection of the three discursive fields discussed above. Figure 6.1 depicts the location of the processes introduced in the Migratory Pathways (and further described in this chapter) within these discursive fields. Step 1, the initiation of the immigration application, is found in the domain of Immigration. Step 2, the IME, is a medical encounter uniquely located at the intersection of Immigration and Medicine. The TB Furtherance process (Step 3) is the follow-up required for the completion of the IME (and potential treatment of active TB), which takes place within the domain of Medicine outside the jurisdiction of Immigration. The referral

Figure 6.1 Overlap of Discursive Fields Along the Migratory Pathway
for IMS (Step 4) is initiated after approval of the immigration application and is situated exclusively within the discursive field of Immigration. The initiation of IMS (Step 5), which requires contact with public health officials in Canada, is located at the intersection of Public Health and Immigration. Step 6 – the required medical assessment as part of IMS – takes place either solely within the discursive field of Medicine (Step 6a) if conducted by a general practitioner / family doctor, or, if conducted at the TB Clinic (Step 6b), occurs at the intersection of Public Health, Medicine and Immigration (sometimes the completion of IMS requires both Step 6a and 6b).

This figure illustrates that various processes encountered by ‘applicants’ (a term I will use to refer to participants between Stages 1-4) and ‘new Canadians’ / ‘newcomers’ / ‘immigrants’ (the terms that describe participants between Stages 5-6) throughout the immigration and settlement process are at times located at sites where these domains overlap. While this intersection may result in policies and programs that “overlap and reinforce each other” (Shore & Wright, 1997, p. 22), it can also have the opposite effect due to competing logics that operate within each discursive field. The results presented in this chapter (as well as the next) do not merely describe the behaviours, actions, and practices of social actors (both experts and participants) in each encounter, but rather frames and interprets them in the context of the network of power that arises from the intersection of these three sets of operating logics. In the remaining sections that follow, I will describe the new fields of power that arise and explain the dominant ways in which participants negotiated power at these new sites in their journeys along the Migratory Pathways. Because the focus of analysis is the medicalization of the immigration and settlement process, the presentation of results begins with the IME.

3 Understanding the Immigration Medical Exam (IME)

Immigration policy dictates that all applicants for permanent residency (PR), and certain applicants for temporary residency (TR), require medical screening to determine their biological suitability as potential Canadian residents. Given the low incidence of TB in Canada and the disproportionate burden of TB among immigrant populations, TB is discursively constructed as an imported disease and a foreign biological threat (this point was previously established in the Background chapter of this thesis). Therefore the biological suitability of immigration applicants depends, in part, on the presence or absence of TB infection.
The immigration system relies on epidemiological science to identify potentially pathological populations where TB is prevalent. Foreign nationals from 146 ‘designated countries’ are automatically discursively constructed as ‘high-risk’ for TB simply due to their nationality and/or citizenship (although others residing in ‘high-risk’ regions may also be categorized as such through the immigration process). Individual applicants from these ‘high-risk’ populations are targeted for medical screening as a means of identifying and discursively separating healthy foreign bodies from those found to harbour TB infection. The diseased bodies are in turn classified according to the nature of the TB infection (active pulmonary vs. active extrapulmonary vs. latent) and, by extension, the inherent ‘danger’ that they pose to the safety of Canadians. Applicants found to have active pulmonary TB disease are considered most ‘dangerous’ and are refused entry until the source of the ‘danger’ is eliminated. Conversely, applicants with latent infection or non-infectious active TB are not considered to pose a ‘danger’ to others, but are rather ‘at risk’ of becoming ‘dangerous’ at some point in the future.

This logic shapes the immigration process in several ways. First, in order to determine whether an applicant is a suitable candidate for immigration or not, they must report the ‘truth’ about the state of their health, past and present, on the immigration application. Applicants themselves, however, are not considered credible sources of such truth; only certain medical experts who have been approved by CIC to conduct medical assessments in the context of the immigration application (Panel Physicians [PP]) have the authority to make claims about the state of an applicant’s body. Second, the discursive construction of ‘high-risk’ populations assumes that all applicants from certain countries are, to some extent, diseased and ‘dangerous’. This discourse of suspicion implies collective ‘guilt’ in the form of infection where ‘high-risk’ applicants are presumed guilty of posing a ‘danger’ to Canadians until proven innocent through medical testing. Against this backdrop, the IME becomes a process whereby applicants must prove their individual somatic ‘innocence’. Medical clearance, therefore, requires the authority of specific medical experts (PPs) to corroborate and legitimize applicants’ assertions of their biological suitability for immigration (e.g. ‘innocence’ from infection / from posing a ‘danger’) in order to be considered admissible as immigrants to Canada.
3.1 The Discursive Nature of the IME Encounter

The primary purpose of the IME is to conduct a medical assessment of an applicant’s body not for the provision of medical care, but rather to assist the state in selecting suitable applicants for immigration to Canada. As such, the PP provides a service for the applicant and the state. But how exactly is their role defined and shaped by the overlapping policies, and what effect does this have on applicants? First, while the PP is “bound to the same professional integrity and ethical standards required by all medical professionals” (Elien-Massenat, Medical Advisor IRCC, personal communication, August 2017), they conduct medical examinations of immigration applicants on behalf of, and as a service to, the Canadian government. Their professional responsibilities in this capacity are specified by CIC. They include “conduct[ing] medical examinations, arrang[ing] for diagnostic tests and investigation, and complet[ing] immigration medical forms accurately” (Elien-Massenat, personal communication, August 2017).

As medical professionals, however, physicians’ conduct (in their role as PPs) is also determined by medical principles and ethics. According to the Canadian Medical Association (CMA), conducting medical assessments for the purposes of an immigration application falls under the category of “completing third-party medical forms” (CMA, 2010). While this policy document outlines the roles and responsibilities of physicians acting in this capacity, it is unclear whether the IME as a service provided by the PP is conducted on behalf of the third party (government) or the patient (applicant). This raises questions about the nature of the relationship between the PP and CIC, as well as the PP and the applicant, and highlights the ambiguous position of the CMA with respect to whom the physician is accountable to (the third party or the patient?). On the one hand, conducting third-party medical assessments falls “outside the physician-patient relationship and that in completing the form, the physician owes a duty to the third party to accurately and objectively report upon the patient’s condition” (CMA, 2010, p. 3); this implies that the PP is primarily accountable to the Canadian government. On the other hand, however, if one considers economic compensation for the medical service provided as an indication of accountability, the opposite can be deduced. Although physicians are recruited by the Canadian government to conduct medical assessments of immigration applicants, “Panel Members are not employees of [CIC], but rather serve as third-party physicians” and “are paid by the applicants
for performing medical examinations” (Elien-Massenat, personal communication, August 2017).

Given that applicants are not regarded as patients in the context of the IME, but rather as customers (or ‘clients’, as per CIC [2016a]), the nature of the PP-applicant relationship is defined by CIC as a consumer relationship where the physician provides a service for fee to the applicant. According to this interpretation, the medical practitioner ought to be primarily accountable to the applicant rather than the Canadian government.

The discourses used to describe the roles and responsibilities of various social actors involved in this process reveal that the IME medical encounter is shaped by competing logics of Immigration and Medicine, which has implications for the ways in which both PPs and applicants are governed. While the nature of the PP-CIC and PP-applicant relationships remain unclear, it is noticeable that the PP-applicant relationship is different from the typical doctor-patient relationship encountered in clinical practice. It is in this context that participants’ accounts of the IME encounter, and the ways in which they negotiate power with PMs, are interpreted in the next section.

3.2 IME: Negotiating the Medical Encounter

The professional responsibilities of PPs are contrasted with the objectives of applicant patients, which are to obtain sufficient medical clearance necessary for admissibility to Canada. The ways in which study participants conducted themselves during the IME process were shaped by the discourses operating at this site and are a direct reflection of their objectives as CIC applicants. Study participants used either one or any combination of three strategies for negotiating these encounters: compliance, active participation, or resistance.

3.2.1 Compliance

All participants expressed that the IME was a compulsory component of the application process. As such, most did not believe that they were in a position to challenge the opinions, or resist instructions, of doctors and officials during the medical examination. Sentiments like “I don’t have any choice and I would want to abide by the rules of the country that I’m going to” (Memphis, Interview) were common. While all participants in this study understood the importance of obtaining medical clearance for their admissibility to Canada, most were unaware
of the implications that a TB diagnosis (latent or active) would have for the application process or the approval of their application. In effect, compliance with the IME was the most common response and did not appear to depend on the individual’s health history.

Study participants who considered themselves ‘healthy’ (e.g. those who had never had a history of TB prior to their IME) (Sunny, Eve, Jane, Memphis, David, and Fiona) were shocked by their initial findings of an abnormal chest x-ray; they had initially perceived the IME as “just a formality” (Memphis, Interview) and did not anticipate that a hidden illness or condition would be detected through this assessment. Not yet knowing their diagnosis, applicants willingly submitted to further medical testing (via referral for TB Furtherance) in order to better understand their own health, to potentially seek treatment, and to eventually obtain medical clearance. These fears, however, were amplified due to CIC policies in regard to PPs’ communication (or non-disclosure) with IME ‘clients’. Although PMs “have a duty to inform applicants of suspicious finding[s] detected during an examination…[and] should emphasize the importance of obtaining timely medical attention”, they are also “told simply to request additional testing [for the purposes of the CIC application]…[and are] instructed to not provide the client any [sic] indication as to how [CIC] will interpret the immigration medical examination” (Elien-Massenat, personal communication, August 2017). This means that while the PP may explain the potential nature of the clinical findings (e.g. abnormal chest x-ray), they are not permitted to speak about the potential implications of this finding for the status of the CIC application (though some PPs reportedly disregarded this rule and counseled study participants on this matter). Given that these clinical findings revealed an unexpected underlying health condition that might perceivably result in inadmissibility, the inability to discuss the implications of these findings with the assessing PP was a source of anxiety for applicants at this stage of the Migratory Pathway.

3.2.2 Active Participation: Co-construction of the IME Medical File

Those individuals who had a previous history of TB (Awnghayi, Michael, Stacey) or those who were aware that their chest x-rays would be abnormal due to other health conditions (John, Zara) approached the IME differently. In contrast to passive compliance, these participants actively engaged in co-constructing their IME medical file with the PP. They made sure to provide the PP with all possible medical information (such as a list of medications taken and duration of
previous TB treatment, or copies of medical files including x-rays, test results, and diagnoses) in order to prove that they were either no longer infectious or that their condition is not related to TB. For instance, Zara and John both kept copies of their medical files documenting their previous ailments, and presented these to the PP.

…They [did] the chest x-ray, which obviously was not normal, and I was aware, because when I had the infection in 2008 I was told that this chest x-ray would remain the same all your life; the shadow will be there in all your x-rays. … [I took] a letter from my doctor that this is what I have gone through and this is what the shadow in my lungs is all about. … [The PP] obviously asked me, “Did you had a TB before?”, and I gave her the same story and explanation about my accident, about the other things, and the medicine that I have taken. … I gave them all my x-rays. So all my previous x-ray as part of my treatment and as part of my, you know, medical examinations for my jobs and my [previous] visa applications, everything I gave, when I applied for my work permit for Canada. (Zara, Interview)¹

While some were confident that their previous health conditions would not negatively affect their application, others were not so certain. Despite fears that her past active TB infection might result in inadmissibility, Stacey believed that honesty and disclosure about her health history was still the best approach to obtaining medical clearance:

People from back home told me I don’t have to write ‘I have tuberculosis’ on the form. … They got me, like, scared [saying] “they’re going to revoke your paper. You’ll not get through. You’ll not get into Canada. You will [be] stuck on [this island] forever”. … I said, “No”. I took my tuberculosis medical card with all my medication I was taking … written on it. When I went to my [IME] doctor’s appointment, I told her, “here it is. I was diagnosed with tuberculosis”. People tell me I was stupid for saying that,…but I didn’t find it too stupid. (Stacey, Interview)

This act of transparency or confession was a deliberate strategy employed by participants to convince the PP that they no longer (or never did) pose a ‘danger’ to public health.

3.2.3 Resistance: Challenging Experts and Negotiating the IME Process

Disclosure (or confession) of one’s past medical history had different effects for different

¹ Italics in participants’ accounts reflect participants’ own emphasis in speech while recounting their experiences.
participants. Those with a history of TB eventually succeeded in their objective of proving that they were not a ‘danger’ and obtained medical clearance. Zara and John, however, faced additional difficulties in meeting their objective. Although Zara’s application was eventually approved, the IME process had not proceeded as per her expectations. By providing the PP with all her medical records up front, Zara expected that the assessing physician would rule out TB as a possible option and she could avoid having to undergo further (costly and time consuming) testing:

I was expecting [that] if I submit my old x-rays – all my documents – probably it would be easy. But it was not. So, after my initial examination … I was asked to come again for a medical exam; I did my x-ray again … then after a month of follow up they asked me to visit a chest physician, do a ultrasound again, you know, to see whether I have an infection or anything just to give a clearance. … Many of time I have to approach the doctor to check whether my tests were okay, will I have to go to additional, because I was in a job which required a lot of travelling to US and other countries and my passport was with the consulate. I have to travel, [but] I have to also, you know, wait to see whether my medical has been cleared. (Zara, Interview)

Zara’s approach reveals an underlying objective of some applicants to not only obtain medical clearance, but also to complete the IME as quickly and easily as possible. Because the delays resulting from a referral for TB Furtherance interfered with her ability to travel for work, Zara had to more actively engage in negotiating the IME process. This involved repeatedly contacting the PP and other immigration officials beyond what is typically expected or required of applicants.

John was equally proactive in negotiating the IME process. In his prior medical assessments with a General Practitioner (GP) to investigate the cause of his abnormal chest x-ray, John was assured that his condition was not related to TB. The PP, however, refused to consider John’s old medical files. Instead of passively complying, John challenged the PP’s decision and attempted (albeit unsuccessfully) to persuade him to reverse it. He explained that this previous assurance from another medical expert gave him the courage to challenge the PP’s decision to refer him for TB Furtherance:

[The GP] said he sees [the same symptoms that I have] on a regular basis, and that made me feel so calm. … And that's why I went “okay, I am not concerned and I will fight!” Because there's someone who's telling me something that I go, “oh, then I am not in a
rare category!” ... [O]nce I was told, “no, I've seen that many times before; it’s just not something that you should be concerned about”, I jumped on that train and said, “all right, then. I'm not concerned”. (John, Interview 1)

This reveals the effects that a medical experts’ approach to normalizing a potentially stigmatizing medical condition can have on an applicant’s thought process and conduct during their migration journey. It also indicates that an applicant’s seemingly unrelated social encounters at various points in their life can actually influence each other and, directly or indirectly, affect the course of the immigration process. In the end, although John’s strategy to resist the PP’s subjectivation was unsuccessful and John was ultimately referred to the TB clinic for furtherance, he continued to actively negotiate power throughout this process with the PP and his staff.

3.3 The Discursive Nature of the TB Furtherance Encounter

TB Furtherance is a secondary part of the IME process when symptoms or chest x-ray findings suggest potential active TB. At the request of CIC, the PP refers the applicant to a TB specialist to undergo an additional medical assessment to establish whether an abnormality detected on the chest x-ray is caused by TB infection. TB Furtherance often involves a number of different diagnostic and laboratory tests and requires numerous encounters with various health care providers. Discursively, the primary difference between the IME and the furtherance process is that the latter is situated solely within the domain of Medicine, though it may not seem that way to the applicant. As such, the doctor-patient encounters are informed by the logic of medicine (as opposed to immigration) and take on a more traditional structure than the encounters between the PP and the applicant. In fact, the applicant is no longer regarded as a ‘client’ but rather a patient. Furthermore, the TB specialist (and other medical professionals) is governed primarily by ethics of medical practice and functions as a clinician first and foremost, not as a third-party physician. While differences can be expected in the individual approach to medical practice of individual physicians particularly in an international context, it is assumed that the doctor-patient relationship takes precedence during TB Furtherance where the principles of duty to care and advocacy for the patient remain the primary objectives.
3.4 TB Furtherance: Negotiating the Medical Encounter

The objectives of TB furtherance patients at this stage of the Migratory Pathway remain the same as described above – to obtain sufficient medical clearance necessary for admissibility to Canada, and to do so as quickly and efficiently as possible. Those whose test results reveal an unexpected medical condition also have a genuine concern for their own health, however this aspect is often secondary to passing the IME. The explicit disclosure of these underlying assumptions once again highlight the conflict between the goals of the TB specialists and the patients which is useful in interpreting the negotiation of power during the furtherance process. Below I present the most common strategies used by participants to negotiate the TB Furtherance interpersonal medical encounter.

3.4.1 Compliance: Accepting Diagnosis & Testing Procedures

Similarly to what was described in the previous section, most study participants accepted all tests and procedures that were required of them to complete the furtherance process having deemed these compulsory and non-negotiable. Even when participants perceived inconsistencies and redundancies in the testing that took place during the IME and furtherance, such as Eve who was asked to repeat sputum induction by TB specialists despite having completed the same test with the PP, they did not question or challenge the doctors when they were instructed to undergo these procedures. This held true for both groups of participants (new diagnosis / investigation vs. confirmed old TB) as well as those with other health conditions that presented as possible TB but which were confirmed to be unrelated (Zara, Andrew); most participants expressed the same desire to complete TB Furtherance as a means to prove that they are not ‘dangerous’.

Through more open communication with patients, comprehensive health education, and medical counseling about TB in relation to what applicants encountered with PPs, participants expressed being more accepting of a TB diagnosis, even for Michael who was required to complete treatment for active pulmonary TB in order to obtain medical clearance. Understanding TB in biomedical terms was generally helpful in dispelling stigma and fear about their potential condition. While some reactions to an LTBI diagnosis (suspected or confirmed at this stage in the migration process) included concern:
My work environment back home [was] a bit more advanced than I could say to another place in my country, so I couldn’t understand how I got it. So, it’s been pretty much a scare to me because I don’t know anybody who had TB, like, on my [social] network; … I’m pretty much the first. (Memphis, Interview)

and embarrassment:

…whenever I’d have to, like, tell people around me, I’m like, “Oh, I have to get this thing, and they needed further examination for TB … I guess because I’m from [home country]” … [T]hat’s the only part that’s kind of … embarrassing. And people just kind of, like, joke around, you know? And I guess to a certain extent it kind of makes you feel- - I don’t know if I’d say ‘inferior’ but, definitely, like, talking to other Canadians, like, … “you don’t have to go through [that] … to live here”, you know? (Jane, Interview)

others actually responded with humour:

… the fact that I have tuberculosis and that it’s latent-- I’m taking it really positively [Eve says with a smile]. I think it’s really funny, honestly, because it’s totally treatable, so it’s … not bad. I mean, it could be totally worse. (Eve, Interview)

The varied responses to a TB/LTBI diagnosis among participants revealed an interesting insight: participants were less fearful and more accepting of their diagnosis if the assessing physicians had prior experience medically evaluating CIC applicants as well as the knowledge about how a TB diagnosis might affect the immigration process and status of the patient’s application. Those participants (Michael, David, Sunny, Eve, Fiona) whose physicians communicated the implications of the TB Furtherance findings on admissibility perceived their diagnosis as a mere nuisance to obtaining their visa or PR rather than a serious health problem: “I was told that I may have [latent TB], and that doctor told me that ‘don’t worry about it’, but, like, it might take a longer time, like, two more months to receive the student visa” (David, Interview). In effect, having an experienced medical practitioner address the immigration component in the context of providing care for TB helped participants to frame their diagnosis as nothing more than an administrative hurdle.
3.4.2 Resistance: Rejecting Diagnosis & Challenging Procedures

Three participants (Margaret, Jane, and John) displayed recalcitrant behaviour during the furtherance process by either rejecting their diagnosis or by challenging the TB screening and diagnostic procedures. These individuals relied on their formal education (Margaret), drew on the professional medical knowledge of their family members (Margaret’s husband who is a doctor; Jane’s sister who is a GP), actively sought out and studied clinical guidelines for diagnosing TB (John and Jane), or relied on their previous experience with immigration medical testing (Margaret, who was applying for dual residency in Canada and another country) to negotiate the clinical encounters with TB specialists.

During her TB Furtherance clinic appointment, Margaret expressed her annoyance and frustration at having been referred for TB Furtherance by answering questions in anger, avoiding eye contact, shrugging her shoulders, showing more interest in eating rather than actively engaging with the assessing physician, and making condescending remarks. She took up biomedical discourses (albeit incorrectly) in an effort to reject the interpretation that her abnormal chest x-ray or positive skin test result were an indication of TB infection, presenting alternative interpretations instead (e.g. insisting that the abnormal x-ray is due to an old rib fracture and the skin test results are a false positive due to BCG vaccine received in childhood), both which were subsequently rejected by the TB clinicians as inaccurate. She also drew on epidemiological discourses and historical and political explanations of the healthcare system in her home country (which is a “designated country” according to CIC) to support her claims that it is not possible that she had ever been exposed to TB because people were mental when it came to all the contagious diseases and inoculation. It was impossibly strict, and that’s why at that point in time [when she lived in her home country] they almost eradicated everything. … [Since then] the health system fell apart, but I grew up when … it was still--., everything controlled. (Margaret, Observation)

The reason for Margaret’s discontent and reluctance at having to complete TB Furtherance was revealed at the end of the appointment:

I just would like it to be over because I don’t understand why there’s such disparity [between the Canadian and British IME] - in England I’ve been cleared. … I’ve done the
same x-ray at the same [clinic], it’s just in England it’s been interpreted by *English* doctors, and for Canadian Immigration it’s [Canadian] doctors. (Margaret, Observation)

Having accepted the need for additional TB screening, in contrast to Margaret, Jane and John’s resistance strategy focused on challenging the order of diagnostic procedures. Given that both Jane and John had deadlines for the completion of their CIC applications, their concern was more with the time it took to obtain medical clearance rather than the concern for their health: “I don’t even *care* if I have TB – I just [Jane laughs] care that my residency is now gonna take two extra months [Jane laughs again], that’s it” (Jane, Observation 1). Having attempted to understand the clinical guidelines for diagnosing TB infection, both participants tried to persuade the clinic staff to do a TB skin test first (which would provide results within 48-72 hours) rather than culture TB (a test which requires 8 weeks to obtain results). To their dismay (both Jane and John broke down crying during their first TB furtherance appointment at the TB clinic), neither was able to influence the clinic staff to alter the diagnostic procedures in their favour. These results demonstrate that applicants most likely to object during the IME process are those who: have prior medical evidence or expert opinion ruling out TB infection (John, Margaret); believe that previous exposure to TB is unlikely or impossible (Jane, Margaret); and / or cannot afford to submit their IME past a certain deadline as it may jeopardize their immigration process.

### 3.4.3 Active Participation: Moderating Communication Between PPs & TB Specialists

The competing logics that inform the professional objectives and duties of PPs and TB specialists give rise to an unexpected network of power relations that implicates PPs, TB specialists, and CIC applicants in a unique encounter. Confusion over which stage of the immigration process the in-Canada applicant (as patient) was being assessed for at the TB clinic (IME vs. IMS) and what medical evidence was required for submission to CIC resulted in the submission of incomplete medical reports from TB specialists to the PP and raised suspicions about the legitimacy of the TB specialists’ claims about their patients’ diagnosis.

I finally went [to see the PP] and I was like, “…What are you waiting for? … *What* do you need?” And he’s like … “On this online application, I have to *insert your first* chest x-ray, then the *report* that says you don’t have [TB], and then [the TB clinic] has to do another chest x-ray and *that’s* what I need.” I’m like, “Oh! So, I needed to get *another* chest x-ray from [the TB clinic]”. He’s like, “Yes.” And I’m like, “Why doesn’t [anyone
at the TB clinic] know this?!” So I called them and I’m like, “So what [the PP] needs is you guys to do a chest x-ray so you can say, in fact, ‘no there’s nothing wrong’”. And the doctor said, “well, we didn’t think it was necessary because with the sputum test we realized that you’re fine and you don’t need anything else.” And I’m like, “I know, but online they need to insert the second chest x---; I just need --- “, and they’re like, “Well, you can have [the PP] call me”. I’m like … “shouldn’t you guys-- like, you guys are connected. You guys should be doing this,” you know? But I did it anyway just to make sure it was getting done. (Jane, Interview)

… [After the PP] still didn’t give me an affirmation saying “yes, you’re cleared, you’re fine” [I followed up with him to ask if the IME report was submitted, and] he told me that, “No, because [the TB specialist] and I made an appointment for a year from now they don’t believe that I’m actually cleared”. [The immigration part has been satisfied,] but because we made another appointment they don’t know why and they can’t understand why so they want to have their own people look at [another x-ray]. [So] I came back to the [TB clinic] and picked up an x-ray; they were gonna mail it, but I was like, I would like to know that these things are happening and not be at the mercy of the post. (John, Interview 2)

In Jane’s case, because the TB specialist determined that a follow-up chest x-ray was not medically necessary to confirm her diagnosis and (erroneously) believed that the additional image was not necessary for the purpose of immigration, Jane had to personally arranged to take another x-ray in order to complete her IME requirements outside the TB Furtherance encounter. In John’s case, because the abnormality on his chest x-ray was determined to be unrelated to TB, the TB clinicians (as pulmonologists) recommended ongoing follow-up to monitor his condition in the interest of his own health as a new Canadian immigrant.

In response to the conflict between the PP and the TB specialists, applicants had to actively participate in negotiating this encounter. In having to “chase some things down” (John, Interview 2) and “doing all this legwork” (Jane, Interview), both Jane and John took up the role of ‘moderator’ and actively co-constructed their immigration medical files during the TB Furtherance stage in an effort to obtain medical clearance. Moreover, these encounters indicate that participants were not the only social actors who contested and negotiated their medical diagnoses; a closer examination of participants’ accounts reveal that underlying competing logics may give rise to conditions where certain medical experts challenge each other’s professional opinions in the context of immigration. Considering that “[b]eyond having an acceptable medical qualification, there are no specific restrictions as to the specialty” or field of practice of
physicians working as PPs (Elien-Massenat, personal communication, August 2017), it is worthwhile to question exactly whose professional opinion is considered legitimate by CIC, and which experts have the authority to make definite claims about a CIC applicant’s health status. These conflicts between experts raise the question about whether the IME system functions as intended, screening those who are legitimately at highest risk of a serious health condition, or whether resources are being unnecessarily wasted because of underlying competing logics guiding the practice of immigration medical screening. John captured this quandary in the following statement:

[T]he only frustrating part is that I know my situation and maybe my doctor does, but really when it comes to two different doctors, plus me, plus a former doctor [of mine] having [ruled out TB], that paints – in my mind – a pretty good picture. … I’m not a threat. Let’s spend some time helping someone get through their things, if that’s the case. I mean, if that’s what we’re here to do then let’s. (John, Interview 2)

These examples point to the possible and potentially conflicting ways in which a discursive field dictates certain medical practices along the Migratory Pathway and highlights the extent to which this shapes the possibilities of negotiating medical encounters for applicants.

4 Understanding Immigration Medical Surveillance (IMS)

In most cases, study participants expected that the Canadian government’s concern with their health in the context of immigration had ended after completing the IME. In reality, however, for those identified as ‘infected’ with TB (whether confirmed or suspected), the IME was only the first component of this medicalization process; immigration policy dictates that applicants who have completed the IME and TB Furtherance (or those with a previous history of TB) must report to public health authorities in Canada for immigration medical surveillance (IMS) and undergo another round of medical testing to (once again) either rule out active TB infection, identify and provide treatment to those with active TB, or identify those with LTBI and offer prophylactic treatment. Thus the IME (including TB Furtherance) is the first step in medically screening applicants, whereas immigration medical surveillance (IMS) functions as the second step, involving both secondary screening and surveillance.
The process of medical surveillance is complex and multifaceted and must be examined in a way that allows for a comprehensive analysis of study data. In this section, I outline the underpinning logics that shape institutional practices at various steps of the IMS process. I then describe the discursive effects of these practices on social actors involved in IMS before presenting the study findings pertaining to participants’ strategies for negotiating encounters throughout this process. Most participant data relevant to the IMS process are included in this section; those findings specific to the IMS experience at the Canadian TB clinic are presented in the following chapter.

4.1 The Logics & Institutional Practices of IMS

IMS involves interactions and overlap of all three discursive fields: Immigration, Public Health, and Medicine. At its onset (referral for IMS and contact with public health), the IMS process is shaped through the articulation of Immigration and Public Health logics and applies only to a select group of new immigrants. Applicants whose CIC applications (for temporary or permanent residency) were approved but whose IME results were interpreted by the Canadian government to be indicative of “a medical condition of public health significance in Canada” (CIC, 2014a) are required to “communicate with” public health authorities upon arrival in Canada. Most often, this is communicated to successful applicants in writing upon receiving their immigration visas / residency papers. Once an applicant has been identified as requiring IMS (and thus, once again, discursively constructed as a potential biological ‘danger’ to Canadians), CIC forwards personal information about the applicant to provincial and territorial public health authorities to ensure that if the individual fails to comply with these instructions, public health officials will be able to establish contact with the individual. According to CIC, Canadian public health authorities have a “responsibility to conduct a medical follow-up” with newcomers referred for IMS and must submit a “notice of compliance [to CIC] when a client starts medical surveillance” (CIC, 2014a).

Once a newcomer has reported to public health authorities for medical surveillance, they become a public health client. The TB public health nurse collects and records personal information (“name, address, immigration information, and [health information] including past history of TB” [Toronto Public Health, 2017b]) about the client. After this, an exchange of official forms takes place: the newcomer must submit their IMS referral form to public health, and, in turn, public health mails the client a letter with instructions outlining the IMS requirements for a follow-up medical assessment.
In most cases, the IMS medical assessment takes place in primary care practice (Rea, personal communication, 2017), which locates these medical encounters strictly in the discursive field of Medicine. Less frequently, however, IMS medical assessments are conducted by TB specialists at designated TB clinics via referral from public health either immediately following initial contact (thus circumventing primary care altogether) or after completing an assessment with a GP. In contrast to medical assessments conducted in a primary care setting, the TB clinic IMS medical encounter is situated at the intersection of Medicine, Public Health and Immigration (a point which I elaborate on in section 5). While TB specialists may be familiar with IMS requirements, many “walk-in physicians have never [conducted an IMS medical assessment] before and know very little about TB” (Rea, personal communication, 2017) or the IMS process. As such, public health officials have prepared an instruction letter providing guidance for GPs in conducting a medical examination to diagnose (or rule out) TB. It is therefore necessary for newcomers to obtain the medical assessment instruction letter from public health prior to seeking an IMS consultation with a doctor.

After the IMS client completes all necessary medical tests, she or he must ensure that the assessing physician faxes the results to public health authorities. These clinical and laboratory findings constitute the scientific evidence as proof of both innocence (refuting ‘dangerousness’) as well as compliance with CIC. As such, this step is “an essential part of the medical surveillance system” (Rea, personal communication, 2017). Once all supporting clinical documentation has been received by public health and evaluated as meeting IMS requirements (the patient must be diagnosed as having “no active TB”), public health officials confirm with CIC that the ‘condition of landing’ has been met”, prompting CIC to remove this condition from the newcomer’s immigration file (Rea, personal communication, 2017; Toronto Public Health, 2017b). Lastly, public health provides the client with an official letter of IMS completion and proof of compliance which (s)he is required to provide a copy of to CIC (Toronto Public Health, 2017b). Thus IMS entails the newcomer navigating the medical and public health systems to obtain the opinions of specific experts in order to remove the condition of landing imposed by CIC and ultimately secure their immigration status in Canada.
4.2 The Discursive Nature of the IMS Process

The IMS process has a number of discursive effects for medical professionals as well as applicants. Requiring newcomers to repeat the medical examination process implies to the newcomer that the Canadian government has underlying suspicions about the legitimacy and quality of medical testing ‘overseas’, suggesting that the medical examination process in other countries is inferior to the Canadian system thus rendering the medical results of the IME only marginally reliable. Moreover, the competing prestige, perceived status, and authority of various physicians (i.e. foreign physicians vs. Canadian physicians; PPs vs. TB experts, etc.) implicitly and explicitly defined by CIC, constructs but one of many networks of power which newcomers must negotiate, often creating problems for applicants.

The intersecting logics also shape the roles of physicians conducting medical assessments for IMS in a primary care setting. Public health authorities encourage newcomers to have their family physician perform this medical exam (or, alternatively, a walk-in physician if the former is not accessible). IMS medical examinations, however, are not standard or common practice for GPs. As such, physicians must closely follow public health instructions for diagnosing TB. In this regard, GPs act as third-party physicians in the context of IMS. While this medical encounter draws a strong resemblance to the IME, there is a clear distinction to be made between the role of the PP and the primary care physician, primarily because the IMS medical assessment is not conducted at the directive of the Canadian government but rather at the directive of the patient herself. The family physician is therefore accountable to the patient rather than the state.

Furthermore, it is important to highlight the difference between a PP-'client’ relationships and that between a primary care physician and patient; while the former is brief, impersonal, and transactional by nature, the latter is involved and personal and takes on a dimension of an ongoing partnership.

The most noteworthy effect of an IMS referral for newcomers is the repeated discursive construction of applicants as ‘dangerous’ after already having dispelled such allegations. Participants perceived the completion of the IME and resultant approval of the immigration application to mean two things. First, because applicants were assessed by medical experts and received medical clearance they presumed that any potential health concerns raised during the IME have been ruled out through rigorous diagnostic testing (unless specified otherwise),
particularly if they did not experience any symptoms of TB. As such, participants interpreted this to indicate that they are healthy and disease-free. Second, participants regarded the approval of the CIC application to mean that the Canadian government has accepted the results of the medical examination(s) as legitimate proof that the applicant does not pose a ‘danger’ to the health of Canadians. This understanding provided participants with a sense of relief: they not only felt that they “passed the exam” (Maria and Andrew, Interview) and thus successfully proved themselves as non-threatening and ‘desirable’ immigrants, but also that they had no need to worry about any underlying health conditions.

In the context of immigration and the IMS specifically, the referral for IMS after receiving medical clearance made the job of TB specialists particularly challenging. As physicians, their job is to accurately identify and convey a medical diagnosis to the newcomer as their patient. Given that TB specialists operate according to biomedical logic, any pathology, even an asymptomatic one, will result in constructing newcomers’ bodies as ‘diseased bodies’. This is a challenge not only in light of the asymptomatic nature of LTBI (as well as pre-symptomatic presentation of active TB disease) where typical patients may reject such a diagnosis because they feel well, but also because of the perceived implications of such a diagnosis by newcomers for their immigration status. Thus while TB IMS patients are trying to negotiate the clinical encounter to prove they are not ‘diseased’, TB specialists are simultaneously trying to convey to them that they are, in fact, ‘diseased’. These competing logics give rise to tensions between the TB specialist and the TB IMS patient, structuring the power relations during the medical encounter.

While few participants were made aware during the IME that they would be required to repeat medical testing upon arrival in Canada, to most, the news about post-landing medical screening was communicated via an official IMS referral letter and came as a surprise. Without context or an explanation for the reasons behind the referral, many participants described their confusion over the mixed messages arising from the competing logics (being medically cleared for immigration yet simultaneously referred for IMS). Given their perceptions about what the application approval implied, participants could not understand why they were required to repeat a medical assessment upon arrival in Canada:
I’m not sure why I have to redo it again. ‘Cause I was cleared of tuberculosis when I was still [back in my home country]. Before I got here. Because, in the first place, they wouldn’t have granted me the visa to come in if they know that I was sick, right?

(Memphis, Interview)

Because the approval of the immigration application was understood as being contingent on proving that one is healthy, the reverse was perceived to be true: medical clearance and the subsequent acquisition of an immigration visa were perceived by participants as confirmation that they were, in fact, healthy. According to this logic, participants came to view their health status and their CIC application status as causally related. The subsequent IMS referral, therefore, challenged participants’ confidence about both: they not only began to doubt their own health, but also perceived their immigration status to be in jeopardy because of it. In effect, newcomers approached the IMS process with the objective of proving to the Canadian government that they are not ‘dangerous’ in order to satisfy their condition of landing and secure their legal status as Canadian immigrants.

4.3 Negotiating the IMS Encounters

CIC clearance of the immigrant’s condition of landing rests upon cooperation and communication between primary care (or specialist) physicians, public health staff, and CIC officials. In order to (yet again) prove their innocence to the Canadian government, newcomers require the knowledge and authority of various medical and public health experts to legitimize their claims as not posing a ‘danger’. The expected conduct of newcomers during these encounters, however, is relational to these experts. As such, the discursive construction of newcomers as immigrants, public health clients, and patients have implications for the ways in which new immigrants can effectively negotiate these encounters to meet their objective of obtaining medical clearance. In the following sections, I describe the strategies used by study participants (compliance, resistance, and active participation) in their encounters with public health staff, government employees, and medical practitioners in primary care practice during IMS to meet their desired end.
4.3.1 Compliance: Lack of Autonomy & Fear

Not fully understanding the reasons behind their referral for medical surveillance, study participants regarded compliance with IMS requirements as the only option. Their thinking about IMS was complex, and many participants simultaneously held several, sometimes competing views. All participants complained about the challenges that IMS presented in their day-to-day life (i.e. attending clinic appointments, missing time from work, following up on paperwork, etc.). While they struggled, they accepted it as yet another compulsory step to immigration. On the one hand, many expressed that as newcomers they did not have a right to challenge or resist state power, implying that this is a privilege only extended to Canadian citizens: “we have no choice since we’re immigrants” (Memphis). In that regard, participants implied that they would resist having to report for IMS if they felt that they could. On the other hand, however, participants also viewed IMS as positive, describing it as rational and necessary for ensuring the safety of Canadians:

if it’s in terms of due process [of] migrating to another country – I guess it’s okay. You wouldn’t wanna, like, risk all the other people here in Canada, so it’s important.
(Memphis, Interview)

From this perspective, while newcomers acknowledged the difficulties associated with completing IMS, they believed in the underlying logic of public health and securitized borders.

Others valued the medical surveillance process because it directly benefited them personally. Given that the IMS referral created doubt about their health status, some participants willingly complied with IMS in an effort to ensure that their IME test results (ruling out active TB) were corroborated and confirmed by Canadian physicians.

We just followed all the requirements. Probably it’s better because we get to know what will happen, because we don’t know what is happening to us. Who knows if we have [TB] or not? We don’t know what’s going on in our lungs. So, it’s okay for us that we have also that...doctor that we rely on and know that he’s okay. It’s better that we were able to find out. (Maria – Andrew & Maria, Interview)

In this case, IMS was perceived as enabling as it presented an opportunity to access the Canadian health care system, allowing newcomers to discover more about their health.
In contrast to the above example, some participants perceived medical surveillance as negative. The IMS referral letter states that non-compliance with IMS can “have a negative impact on your immigration application”, listing refusal to extend a visa or permit, or denying Canadian citizenship until medical surveillance has been completed (CIC, 2014a). While the consequences of non-compliance do not affect CIC applications or permits that have already been approved, some participants misinterpreted this warning as much more serious and viewed it as a threat. They became afraid that if they did not comply with IMS, their immigration status would be in jeopardy, or worse: it would be revoked entirely.

I come here [to Canada] and I got a call from the public health. [They said] within one month you have to do the medical exam [because] you have a tuberculosis history, otherwise we would deport you back. (Awngshayi, Interview 1)

This fear and negative thinking permeated all encounters throughout the IMS process for some participants, causing them to perceive public health officials and medical practitioners as threatening. While these participants complied, viewing these experts as authoritative state representatives shaped their conduct throughout the IMS process.

4.3.2 Resistance: Ignoring Instructions & Challenging Procedures

While most participants expressed their frustrations with ongoing and seemingly redundant medical testing during the study interview, they were hesitant to share these views with public health and medical experts. Those who knew they did not have active TB were most frustrated by the requirement to undergo screening because they saw it as unnecessary:

If I’m having [active] TB and I’m not feeling well, then it makes sense to do [medical surveillance and testing] for nine months, you know? If I’m not affected by it, and I’m healthy and I’m eating, and I’m hanging out with friends and I’m not suffering from anything, then why I need to do all those [medical exams and] things again? Does it make any sense? (Sunny, Interview)

Due to fear of potential negative repercussions for their immigration status as well as perceived futility of non-compliance given their status as immigrants, only two participants (Awngshayi, Sunny) reported challenging expert opinions or instructions at this stage of the immigration process. Those that did, however, did so after an initial period of compliance until they felt they
no longer could due to insufficient resources (time, money). Their strategies of resistance included ignoring instructions and negotiation.

Awngshayi faced many challenges living in Toronto alone as a refugee (i.e. unemployment, tuition fees, living costs, break-in and robbery, shortage of family physicians, etc.). A year after completing her initial IMS medical exam, she received a follow-up medical surveillance letter. Given the difficulties and stress of managing her daily life, Awngshayi deliberately ignored the instructions to repeat a medical assessment, complying only when it was convenient for her:

And then [in the summer of 2015], public health contact me again [saying] “you have to do [medical testing] again!” For that, even though they said that, I [was] kind of [a] little bit reckless. I don’t really care anymore, you know? It’s too much for me. [I just] remember [if] I have time, [then I’m] gonna to do it. Because a lot of thing has gone on since I got [to] Canada. (Awngshayi, Interview 1)

At that point in her life, Awngshayi’s fear of authority, which initially motivated her to comply with IMS, was overshadowed by her basic need for survival. Because completion of medical surveillance was no longer perceived as necessary for survival, Awngshayi temporarily dismissed the directive to complete it without informing the necessary officials.

In contrast to Awngshayi’s strategy, Sunny directly challenged the IMS process by negotiating with public health staff about the extent to which he would comply. While he was mentally prepared that he would have to undergo IMS after coming to Canada, Sunny was unaware that his health insurance would not cover the cost of all the medical tests. This unanticipated expense exceeded his budget and he threatened to forgo the remainder of necessary tests unless the fees would be waived. He was eventually referred to a TB clinic where he could complete the necessary medical assessment free of charge.

4.3.3 Active Participation: Seeking Out Medical Clearance

Four participants (Awngshayi, Michael, Stacey, Zara) described being much more involved in the medical surveillance process than what is typically expected of newcomers. Perceiving their referral for medical surveillance as an indication of a threat to their health (Stacey, Zara), their moral worth (Michael), or their ability to remain in Canada as an immigrant (Awngshayi), participants took an active approach to obtaining medical clearance by seeking out not only
information from government offices, health centres, and community institutions, but also medical advice from health care professionals beyond the directives of IMS.

For instance, after Stacey received her PR and IMS referral in her home country, she contacted her mother (and sponsor) in Canada to ask for help in finding out what the medical surveillance process entailed. By the time Stacey arrived in Canada, her mother had already contacted public health and arranged a doctor’s appointment for Stacey within a week after arrival.

For Zara, a desire to enter the workforce, become pregnant, and protect her husband from risk of being infected with a stigmatizing disease created an imperative to seek out assurance from a medical expert to rule out active TB infection. After contacting public health, Zara was “bogged down” to find out that she would have to wait three months until her OHIP arrived to see a doctor: “How long should I wait? I’m here to reunite with my family, to start working again, but I don’t want to infect anybody!” When she finally saw a doctor, Zara found out she would have to wait another four months to be assessed by a TB specialist. Framing her concerns within discourses of risk to the health of her husband and her unborn child, Zara convinced her physician to make an immediate referral for an assessment with a TB specialist outside of the IMS process:

… besides the [clinic] which [my doctor made] the appointment for the medical surveillance thing, she sent me to a [TB specialist] to just ensure that I don’t have an active infection. That was on an urgent basis – [for the] doctor to screen me – because I was very sceptical about starting my family. So, I had that appointment immediately. [The specialist] examined me and gave me a go ahead because I didn’t had any symptoms at that time. And I had some reports of all my x-rays and everything that I have gone through, and with that and whatever little test that they did, he said, “You’re good to go ahead with your pregnancy”. [After that] I was comfortable that [medical surveillance] might take it’s own sweet time, [but I knew that] I am good to do my other things which are more important in my life, and I got pregnant. (Zara, Interview)

As demonstrated in the above account, Zara’s involvement in obtaining health information about her own body extended beyond her acquisition of a specialist appointment; she also actively helped to construct her own medical file by providing the doctors with previous medical reports and images documenting her condition. In the end, Zara’s efforts paid off: the knowledge she gained about her health enabled Zara to take control of her body and her life in a way that she perceived was best for her and her family.
For Michael and Awngshayi, the sense of urgency in obtaining medical clearance drove them to seek out information about the IMS process from sources other than public health. While this action stemmed primarily from a lack of understanding of IMS procedures, the reasons inciting these participants to action differed. Awngshayi’s primary motive was fear of deportation. In an attempt to understand and comply with IMS, she actively sought out information about the necessary steps for obtaining medical clearance from individuals whom she regarded as ‘experts’ on the topic: Service Ontario government employees, multicultural health and community centre staff, and a primary care physician. Having received inaccurate or incomplete information about the medical surveillance process, Awngshayi completed a medical assessment, but with errors. To rectify the situation and meet the IMS requirements, she took on the role of mediator between public health officials and the assessing physician to ensure the mistakes made during the medical exam were corrected. In this way, Awngshayi took on the responsibility for communicating IMS requirements to her physician and became an active participant in the construction of not only her medical file, but also, by extension, her public health and CIC files.

Michael similarly took on a more active stance in obtaining medical clearance. Unlike Awngshayi, however, his motives were not directly related to CIC but were rather more personal. After years of delays, repeated IMEs, and treatment for active TB in his home country, obtaining medical clearance (and approval of his PR application) meant that he and his children could finally reunite with his wife. He expressed that the process was challenging for his whole family because his wife blamed Michael’s medical condition (and, by extension, Michael himself) for keeping their family apart. An IMS referral, therefore, took on a moral dimension and, from Michael’s perspective, raised doubts in his wife’s mind about the legitimacy of his claims of being cured. As a means of proving his moral innocence to his wife and his family, within days after arrival Michael actively sought out information from various officials in an effort to obtain medical clearance as soon as possible. Enlisting the help of his sister, Michael visited Service Ontario government offices, a walk-in clinic, and a community health centre in search of experts who possessed the authority to prove his ‘innocence’ not particularly for CIC purposes, but rather as a means of reestablishing his moral standing.
5 Chapter Summary

In this chapter, I presented the findings that address the first part (part A) of the second research question, which asks *How do immigrants undergoing TB surveillance negotiate power throughout the different stages of the immigration and settlement process in international (pre-migration) and national (post-migration) settings.* I opened the chapter by conceptualizing Immigration, Medicine, and Public Health as separate discursive fields operating according to three different logics. I interpreted participants’ accounts of the medicalization of the immigration and settlement process in the context of these overlapping discursive fields and often competing logics. Using dominant typologies, I have shown the variety of strategies used by participants to negotiate (primarily medical) encounters with various experts and officials as they moved along the Migratory Pathway. Participants exhibited strategies of compliance (or docility), active co-construction of their medicalized bodies, as well as resistance to challenge being constructed as ‘diseased’ and therefore ‘dangerous’ in the context of immigration. As this analysis suggests, participants’ primary motivation for negotiating their discursive construction in biomedical terms was based on their perceived effects of what being ‘diseased’ meant for their immigration status. However, as participants operated according to their own logics and objectives, various experts encountered through this process (PPs, public health officials, TB specialists, GPs) were similarly operating within different logics. These logics typically conflicted with those of participants, giving rise to tensions observed during interpersonal encounters.

This chapter has included participants’ experiences before and after arrival in Canada, up to and including the IMS medical assessment in a primary care setting. In the chapter that follows, I present the remainder of the study findings which strictly focus on participants’ medical encounters in a Canadian TB clinic setting.
Chapter 7
Results III: Negotiating Power at the Canadian TB Clinic

1 Introduction

The findings presented in the previous chapter reveal the various ways in which study participants negotiated interpersonal encounters with officials and experts, both in pre- and post-migration settings, throughout their immigration journeys. Following the chronology of the Migratory Pathways introduced in Chapter 5, the results illustrated in Chapter 6 encompassed encounters beginning with the immigration medical exam (IME) and included medical assessments completed as part of immigration medical surveillance (IMS) in primary care settings. They did not, however, include the final stages of IMS: that is, a medical assessment conducted by Canadian TB specialists. The present chapter resumes at this point in the Migratory Pathway and provides a direct continuation of the chronology established in Chapter 6.

The findings presented here address part B of the second research question, which asks:

*How do immigrants undergoing TB surveillance negotiate power throughout the different stages of the immigration and settlement process: a) in international (pre-migration) and national (post-migration) settings? and b) during the Canadian TB clinic encounters?*

Continuing with the established conceptualization of the immigration and medical surveillance processes as an articulation of three discursive fields (Immigration, Medicine, and Public Health, Figure 6.1), I begin this chapter by delineating the discursive location of the TB clinic and its implication for the roles of clinicians in the context of IMS. Given the importance of the clinic as a site where expert medical knowledge is produced and translated, I highlight some of the ways in which patients are discursively constructed by TB clinicians before describing the structure and procedures specific to the IMS medical assessment. Using dominant typologies, I draw on observational data and field notes to describe the various ways in which participants responded to the clinical gaze, focusing on strategies of active engagement or resistance, as well as their effects. Where relevant, some interview data are also included in this section for those
participants who took part in both observations and interviews; I also included the perspectives and experiences of all participants observed in the clinic (even those undergoing IMS) in my analysis here insofar as they contribute to the understanding of the ways in which immigrant patients engage with clinicians. Having said that, however, my interpretation centres on the role of the TB clinic in assessing patients for the purposes of medical surveillance rather than the IME stage. Lastly, while the description of clinicians’ responses and behaviours form an integral part of the analyzed data, I interpret and present these findings from the perspectives of study participants as newcomers, public health clients, and CIC applicants.

Before I continue, I would like to declare my own views about public health and medical practice related to TB. In no way do I intend for these findings to undermine or delegitimize the TB prevention and control program or the vital work of clinicians whom have dedicated their careers to care for individuals affected by TB. My objective is not to pass moral judgment on all those involved in providing much needed care to some of the most vulnerable populations, but rather to bring attention to some of those practices that have been institutionalized and normalized, yet which may have unintended negative consequences for certain newcomers. I contend that an investigation of the power relations in this setting provides an opportunity for reflection, possibly bringing about change that would be beneficial not only for TB clinicians and public health officials, but also for new immigrants undergoing TB medical surveillance.

2 The Discursive Location of the TB Clinic & Multiple Competing Logics

In the previous two chapters, I have not only demonstrated that the medical assessment at the Canadian TB clinic in the context of IMS serves as the last step in obtaining immigration medical clearance (Chapter 5), but also that this encounter is discursively situated at the intersection of three fields: Immigration, Medicine, and Public Health (Chapter 6, Figure 6.1). The unique location of the TB clinic at the intersection of these discursive fields results in the constitution of practices and conduct for clinicians and IMS patients. By extension, the social and medical encounters between patients and clinicians are shaped by these different competing logics of immigration, public health and medicine, creating the possibilities for newcomers to negotiate these encounters.
Having been discursively constructed by CIC as potentially ‘dangerous’ under suspicion of harbouring TB infection, the objective of newcomers referred for IMS is to seek out medical experts whose authority is recognized by state officials, and who can either support their claims to innocence or provide appropriate therapy to eliminate the source of ‘danger’ (both active TB disease and latent infection). Until medical clearance was obtained, most participants undergoing IMS worried that their current or future immigration status was in jeopardy (Stacey, Michael, Awngshayi, David, Fiona, Sunny, Memphis); one participant (Awngshayi) even mistakenly feared that her permanent residency status would be revoked (despite having entered Canada as a government-sponsored refugee), leading to her subsequent deportation.

In reality, TB specialists are recognized by public health officials to have the most experience and authority to conduct a TB medical surveillance assessment and thus can provide the most legitimate support to newcomers’ claims. Given the classification of TB as a reportable disease, the TB clinic works in close partnership with public health authorities. Despite being situated within the immigration process, while the logics of both public health and medicine inform medical practices at the TB clinic, the logic of medicine and medical ethics takes precedence. That is, while TB clinicians regularly communicate information about patients’ diagnoses or provide updates on treatment of those undergoing therapy in accordance with public health practices, their main objective is providing treatment, care, and support to the individual patient.

As I have already alluded to in Chapter 6 and will further emphasize later in this chapter, the conduct and practices of TB specialists and newcomers referred for IMS are shaped by competing logics. While the objective of the study was to highlight the experience of immigrants, understanding how clinicians and patients both exercise and negotiate power is necessary. With this aim, in the following section (Section 3) I include some findings framed from the perspective of clinicians. Understanding the ways in which clinicians operationalized power provides insight about which strategies of resistance and engagement taken up by patients were effective in this setting and why. As I go on to show, given that CIC medical clearance as well as various economic and social challenges encountered during the settlement period took precedence over concerns about their health, many participants did not approach this medical encounter with the same objectives as the clinicians. While the TB specialist operates with the aim of ensuring optimal health outcomes for the patient, the newcomer patient’s aim is to simply
complete IMS and get on with life. Consequently, these competing logics give rise to tensions during the TB clinic medical encounters.

3 The TB Clinic: Standard Practice and the Construction & Management of TB Patients

3.1 The Clinic Environment

Patients are referred to the TB clinic to either confirm or rule out suspected TB infection. The TB specialists here consist of a nurse practitioner, a TB public health nurse, respirologists, Infectious Disease physicians, and nursing staff. In addition, as the clinic is located in a teaching hospital, there are multiple trainees (residents and nurses) coming through from various backgrounds and specialties. Those found to have active TB must complete a full course of treatment and remain under the care of TB clinic staff. Those with LTBI are also, after screening and diagnosis, offered treatment. This constitutes a substantial component of medical care at the clinic. Patients have the option to complete preventive therapy (chemoprophylaxis) either at the TB clinic or under the supervision of their family physician. Much of this information is shared with the public health department in accordance with Canadian law, and a public health TB nurse is part of the clinic team to facilitate this and other collaborative aspects of TB care.

The data collected during this study indicate that the TB clinic is a very busy and crowded place. With several clinics running concurrently in the same space, this created a clinical space marked by a loss of privacy not only for the individual patient, but also for the doctor-patient encounter. The results of this analysis are influenced in part by the physical constraints of the clinic. As such, these results may not have been the same had the physical space of the clinic been different. Against this backdrop, in addition to ensuring sufficient financial and human resources to provide care to a high number of patients, the success of the clinic rests on the effective and efficient diagnosis and treatment of patients which can best be achieved through patient compliance. While some patients are referred to the clinic voluntarily, such as health professionals and students undergoing occupations screening, most are not. The latter group tends to come from vulnerable communities (i.e. homeless, newcomers, etc.) for whom the burden of TB is highest. Health literacy is lowest among the most vulnerable and presents a challenge for clinicians in terms of patient co-operation because, as one of the TB clinic doctors put it, “if [patients] don’t buy into the whole thing, then it’s pointless” (field notes, July 2015).
This statement implies two things. First, it establishes biomedical logic as the most important logic operating at the site of the clinic, reflecting clinicians’ commitment to the medical ethics of care. Second, in the interest of providing the best medical care, it indicates that a large part of clinicians’ efforts must be dedicated to “selling” the biomedical conceptualization of TB to their patients. Their success in the role as health care providers is therefore in part predicated upon convincing patients to accept the traditional biomedical model and instill health-related values so that they may come to view TB through a biomedical framework and establish therapy (particularly preventative therapy) as a desirable and common goal for both clinician and patient. As I will go on to show later in this chapter (Section 7.5.3), improving patients’ medical proficiency becomes a significant component of the medical encounter.

3.2 Constructing the TB Patient

Several mechanisms are used to construct the TB patient as subject and simultaneously establish the power relations at the TB clinic. While some of the strategies observed at the clinic are common to any medical encounter and result in constructing more traditional patient ‘types’ (i.e. the patient as a medical ‘case’, classifying patients according to their personality traits, rewarding the ‘desirable’ patient who commits towards treatment, disciplining the ‘difficult’ or non-compliant patient, etc.), others are more specific to TB care (i.e. perceiving the TB patient as ‘untrustworthy’). Many, however, are not directly relevant in the context of immigration. Given the significance of medical logic in governing conduct at the TB clinic, it is necessary to understand the mechanisms responsible for the construction of TB patients as medical ‘cases’.

The ways in which patients are constructed by clinicians serves a strategic purpose for their management. The discursive framing of patients not only influences clinicians’ behaviours and attitudes towards patients, but it also sets an implicit expectation for patients to act in accordance with these discursively constructed identities. While there is an implicit expectation that patients understand what it means to be a ‘patient’, it is also expected that some individuals will deviate from this norm. The need for managing patients arises from the competing discourses that govern the conduct of patients and clinicians; because clinicians have a professional duty to cure the biological disease, other aspect of the medical encounter have to be managed and biomedicine must be emphasized. In that respect, the social lives of patients, the economic barriers they face, and all other aspects of immigration are not considered a priority in this setting.
3.2.1 Patients as Medical ‘Cases’

The discursive construction of patients begins well before a patient sets foot in the clinic. In order to prepare for the individual assessment and to structure the clinic, the TB case manager reviews all new incoming referrals to determine the type of assessment required for incoming patients. A new patient file is constructed and individuals are classified according to the referring physician’s complaint as well as the expected or likely pathology (suspected active or latent TB). After an initial assessment or diagnosis has been made, patients are reclassified based on the diagnostic test results and their plan of care.

The clinic relies on physical colour-coded filing system for patient identification. One colour is used for active TB patients undergoing treatment, another colour for patients with LTBI completing prophylaxis, and a third colour for incoming or returning patients who have either not been diagnosed yet or have been diagnosed but are not undergoing treatment. Within this classification system, the patients with active infectious TB are flagged most conspicuously. These files stand out with a brightly coloured sheet which reads “MASK AND ISOLATE” to indicate how such a patient must be managed in the clinic setting to ensure infection control precautions (i.e. upon checking-in for their appointment with administrative staff they are instructed to wear a mask and are promptly moved to an isolation room in order to minimize the risk of transmission of TB to others).

This institutional practice and process of biomedicalization constructs the patient as a medical ‘case’. This ‘case’ identity is not static but rather can change over time according to the nature of the patient’s infection as well as their therapeutic course. While this classification system undoubtedly improves efficiency in the clinic, it may have some unintended consequences for patients. For instance, although the practice of conspicuously indentifying (potentially) infectious patients is underpinned by biomedical logics of infection control and is carried out in accordance with public health and institutional guidelines, the clinical gaze discursively constitutes individuals in terms of levels of ‘dangerousness’. The troubling part lies not with the process of identifying the patient as infectious to clinic staff (which is necessary), but rather in its potential for this marker (a bright page with clear, conspicuous writing) to be noticed by the patients themselves, or worse – by other patients. In the context of the present study, this practice can be perceived as yet another instance of being constructed as a ‘danger’ over the course of one’s
migration journey with the potential to exacerbate the effects of internalized stigma by newcomers undergoing IMS.

4 Understanding the IMS Medical Encounter

In the previous sections, I have described the strategies used by TB clinic staff to construct and manage IMS TB patients. The purpose of the current section is to describe the structure of clinic appointments and the process of conducting a medical assessment for the purpose of CIC post-landing medical surveillance, which provides context for the interpretation of participant observations in the section that follows.

In order to definitively rule out active TB, a patient requires at least two visits to the TB clinic. The purpose of the Initial Visit is to collect information – about the patient’s body (through a clinical assessment and diagnostic testing), about the patient’s biological and social history, biological samples (i.e. sputum) – in order for a diagnosis to be possible. During the Follow-up Visit, an active TB diagnosis is either confirmed or ruled out, satisfying the IMS requirement. If LTBI is suspected, the patient is presented with treatment options during the first (or subsequent) follow-up visit. Clinically, each appointment (initial and follow-up visit) follows a set structure and serves a specific purpose in the context of IMS. I describe the phases and key components of both types of appointments before presenting the findings that directly address the last research question; that is, those specific to the power dynamics and negotiation of the IMS clinical encounter by study participants.

4.1 The Initial Visit

In order to help clinicians accurately diagnose TB, new patients were required to take a chest x-ray and provide a sputum sample (a process that can take up to two hours) prior to their assessment with the TB clinicians. Once the patient returned to the waiting room, a clinician reviewed their file to understand the nature of the referral, the purpose of the visit, and the likely diagnosis; this process helped to inform the clinician’s approach to the subsequent appointment.

The Initial Visit consists of four phases: initial consultation, the physical examination, the “review”, and consultation with the staff physician (a TB specialist). The initial consultation is typically conducted by a nurse or resident (though sometimes the staff physician as well) who
establishes the reason for the referral and conducts an interview to learn the patient’s health history (including TB). It may also include a health education component focused on teaching the patient the difference between LTBI and active TB disease, and (sometimes) the objective of prophylaxis for treating LTBI. While prophylaxis may be introduced during this appointment, a detailed discussion about preventative treatment is typically reserved for the follow-up visit. After the patient interview, the clinician conducts a physical examination and reviews the chest x-ray to determine whether the patient has any physical signs or symptoms indicative of active TB. The information collected through the oral history and physical examination is used to construct the patient’s risk profile for TB. Once this is concluded, the clinician leaves the examination room to conduct a “review” of the patient’s case with a staff physician. In consultation with the assessing clinician, the attending physician reviews all relevant information about the patient (referral, health history, physical examination, and chest x-ray) to make an inference about the most likely diagnostic outcome (pending results of the sputum culture) and decides on the most suitable course of action for the patient. In the last phase of the appointment, accompanied by the assessing clinician, the staff physician informs the patient of the plan of care and, if needed, asks other follow-up questions. The patient is given opportunities to ask the doctor questions or voice any concerns. The typical course of action is for the patient to return to the clinic after 8 weeks for a follow-up visit once the results of the sputum culture are known and active TB can be either confirmed or ruled out.

### 4.2 The Follow-up Visit

The patient’s diagnosis dictates the procedures and structure of the follow-up visit. As none of the study participants taking part in clinic observations were diagnosed with active TB at the time of their first follow-up visit, the appointment structure described below is relevant only to IMS patients who have had active TB disease ruled out.

The structure of the second clinic appointment is similar to the first visit, but consists of three rather than four phases: the initial consultation, the “review”, and the consultation with a staff physician. During the initial consultation, the patient is informed of her sputum culture test results. Depending on the individual’s history with TB and their health history in general, results may indicate suspected LTBI, confirmed LTBI, non-tuberculous *Mycobacterium avium* Complex (NMT, for example MAC) infection (referred to as the “cousin of TB” for which treatment is
typically not recommended), or neither, or another medical condition (e.g. cancer). The clinician presents the patient with options for a course of action (described in section 4.2.1) and engages her in conversation to better understand her intention for the plan of care. This conversation includes a teaching component tailored specifically to the patient’s diagnosis and typically includes the biomedical distinction between active TB and LTBI. For those individuals where LTBI is confirmed or suspected, clinicians emphasize and explain the standard recommendations and procedures for the course of prophylactic therapy framed within discourses of risk and benefit. During the initial consultation phase, the clinician typically explains that the CIC-mandated component of the patient’s immigration application is complete and that these test results satisfy the requirement for immigration medical surveillance.

Both the “review” and subsequent physician consultation proceed in the same manner and with the same general objectives as described in the initial visit. The only difference is the topic of conversation during the “review” which centers on the patient’s attitude towards various therapeutic and diagnostic options. Once the respirologist and assessing clinician establish the most suitable course of action and potential treatment, the pair returns to the exam room. The staff physician consults with the patient negotiating either a treatment plan or an alternative course of action, and addresses any final questions or concerns before concluding the appointment.

4.2.1 The Effects of the Follow-up Visit: Possible Courses of Action

There are four potential courses of action for patients who have had active TB disease ruled out: undergo further testing to confirm or rule out LTBI, begin prophylaxis, ongoing medical surveillance, or discharge from the clinic. First, if the patient expresses an interest in pursuing prophylactic treatment but an LTBI diagnosis has not yet been established, then a tuberculin skin test (TST) must be performed. At the end of the follow-up appointment, a nurse “plants” the skin test, instructing the patient to return in 48-72 hours to ‘read’ the result. Second, if LTBI has already been confirmed and the patient wishes to begin prophylactic treatment, the patient will receive a prescription and begin treatment. Third, if the patient refuses or does not qualify for prophylaxis, the clinicians may decide that the patient’s risk of future active TB is sufficiently high to recommend surveillance (through radiographic monitoring) over the upcoming months or years to facilitate early detection of active TB if it should arise; in either scenario, the patient
schedules their next appointment before leaving the clinic. If the TB clinicians determine that no treatment, surveillance, or further testing is necessary, the patient is officially discharged from care and ceases to be a ‘patient’ at this clinic. Lastly, some patients who initiate either prophylaxis or a series of investigations for another medical condition may not return to clinic and are deemed ‘lost to follow-up’.

5 Negotiating the IMS Medical Encounter

The possibilities and limitations for the negotiation of power during the clinical encounter are shaped by social and institutional factors of the clinic setting (i.e. the ways in which patients are discursively constructed as medical ‘cases’, and the structure and procedural sequence of phases and components of the clinic appointments). Both are defined by clinic staff and are informed primarily by the logic of medicine. Together, these factors demonstrate the ways in which biomedical discourses operate and frame the context – and power relations – for the clinician-patient interactions at the TB clinic.

In the remainder of this chapter, drawing from participant’s accounts and observations of the TB clinic appointments, I present the most common strategies (resistance and active engagement) employed by study participants to negotiate the IMS clinician-patient encounter. Reflecting the style of the preceding chapters, the presentation of results follows a general chronology of the appointment structure. Only those components of the TB clinic medical encounter most relevant in the context of immigration are included here: establishing the reason for the referral, (co)-constructing the patient risk profile and diagnosis, and negotiating prophylaxis. In reading the following sections, it becomes clear that clinicians’ objectives to diagnose and provide medical treatment to IMS patients sometimes conflicts and sometimes aligns with the aims of immigration TB patients. Once again, the tensions between patients and health practitioners in the following examples highlight the effects of the intersection of competing logics that frequently put patients and clinicians at odds over the purpose of the medical assessment.

5.1 “Do you know why you’re here?”: Establishing the Reason for the Referral

At the beginning of each clinic appointment (both initial and follow-up), after a brief introduction, all patients became actively involved in helping clinicians to discursively frame the
appointment by being asked whether they understood the reason for their visit to the TB clinic. All study participants observed during their initial visit were explicitly aware that they were referred for the purpose of immigration medical surveillance as part of their condition of landing and actively participated in this process. Part of establishing the reason behind the IMS referral involved patients recounting their immigration journeys. Depending on the individual’s experience, these narratives were more or less convoluted, but patients always had a complicated story to tell. Although patients framed their journeys within discourses of immigration and settlement, their narratives were interpreted by clinicians through a biomedical lens and used to further discursively construct the patient. By establishing IMS as the reason for the referral, participants actively took part in constructing themselves as the ‘immigrant’ TB patient.

The degree to which clinicians acknowledged the immigration context of the medical encounter varied based on the individual clinician’s experience and knowledge of the IMS process. Staff physicians and TB nurses were more familiar with IMS requirements and thus emphasized the role of CIC for the referral to the TB clinic; residents and other nurses, however, only vaguely acknowledged the immigration context and typically only did so upon the patient’s questioning. The former, more experienced group often (though briefly) acknowledged the obligatory nature of the appointment and explained the IMS process to patients in varying detail because “nobody tells [immigration patients] any of [the procedures]; they just, sort of, send a referral” (nurse to John, Observation 1). At some point during both the initial and follow-up visit, all patients were assured that all information required by CIC would be forwarded to the appropriate authorities to ensure that the condition of landing would be removed from the patient’s immigration file:

… We’ll make sure that that information gets over to Public Health and to Immigration, and that should clear everything up. Ah, sometimes, maybe you might get a letter from Public Health or from Immigration, and maybe there’s some questions – we can help you if you’re having some difficulties with that. … (Doctor to Jergua, Observation)

Clinicians with IMS experience were also more likely to explain to the patient that in the context of medical surveillance, as TB clinicians, they had to simultaneously perform two functions – that of an administrator for CIC, and the other of a health care provider:
Okay. So, you were flagged because of an abnormality on your chest x-ray and that’s what we’re essentially assessing right now. So, the first things is, there’s sort of two roles that I’m gonna be playing here; one of them is an administrative role for Citizenship and Immigration Canada, and the second is just the discussion between you and I about your health – and it has nothing to do with Citizenship and Immigration Canada.

(Doctor to Margaret, Observation)

This approach effectively communicates that while there are certain government procedures that must be complied with, there is also a legitimate concern for the patient’s health and wellbeing. In this way, the clinician establishes their authority in the role as a medical expert outside the IMS context. On the other hand, however, other clinicians informed patients that they were not, in fact, part of the immigration process: “I’ll be very honest. I’m just the TB component; I’m not the immigration [component]; I don’t really know what immigration’s policies are” (nurse to John, Observation 1). In both instances, the clinicians explicitly separated the immigration component of the exam from the provision of medical care. Overall, while some clinicians drew on both medical and immigration discourses to justify the reason for the medical assessment, biomedical logic was predominantly used to discursively frame the clinical encounters and overshadowed the immigration discourses taken up by participants.

5.2 Co-Constructing the Patient Risk Profile & Preliminary Diagnosis

Various forms of information were collected from and about patients to biomedically construct the patient risk profile and infer a diagnosis. Patients were expected to submit to the clinical gaze by complying with procedures and, when necessary, actively participate by providing clinicians with the necessary information about their bodies. As clinicians relied on compulsory procedures to collect clinically relevant information through medical images (x-rays), physical examination, and the clinical interview, this presented patients with limited options for negotiating the medical encounter. While some participants resisted power during the medical encounter, most complied with procedures and actively engaged with clinicians. Ultimately, the ways in which participants negotiated these encounters implicated them in the co-construction of their own TB risk profile.

5.2.1 Producing & Challenging Interpretations of Medical Images

All new incoming patients, particularly those referred for immigration, were required to take a
chest x-ray at the hospital on the day of their appointment prior to their medical assessment. The explanations that some clinicians gave to their patients for this were vague. As one nurse put it, in order “to prove [to CIC] that you don’t have TB, one [of the things] I have to do [is] my own chest x-ray because we’re very snobby people; we like to look at films ourselves” (John, Observation 1). The actual rationale behind this practice was not communicated with patients.

While this policy was in part put in place after it was discovered that some immigration patients had submitted fraudulent chest x-rays as part of their medical assessment to presumably conceal an abnormality indicative of TB (the x-rays were discovered to be fraudulent when the sex of the patient did not match the sex of the individual in the x-ray) (field notes, Aug. 2015), there was also a medical reason for this. It was explained to me that TB is not a binary disease that presents as ‘active’ or ‘latent’ but rather presents along a continuum. Because there is typically a time lapse between the IME and IMS, it is possible that individuals identified as having latent infection could have developed active TB disease in the interim. In this way, the immigration process shaped the institutional practices of the IMS medical assessment at the TB clinic.

The intersection of immigration and medical practice in this context restricted the ways in which IMS patients could negotiate this component of the medical assessment. Given that the x-ray was presented to patients as a compulsory part of their medical care, most complied. One participant, however, resisted. Given her past history of active TB (once at the age of 16; the second time within months of her IME), Awngshayi had to undergo an overwhelming number of x-rays over the course of her life before coming to the TB clinic (repeated imaging while she had active TB and follow-up surveillance after completion of therapy; during IME and TB Furtherance; after arrival in Canada for IMS in a primary care setting). Given her experience, Awngshayi became concerned over the amount of cumulative radiation exposure:

I know there [is] still harm [from x-rays]. [It is] still radiation. … I have read a lot [about it]. … [S]ince I was a 16 I had the so many x-ray – [when I was a refugee in Thailand, I had] so many x-ray. That’s why I don’t really like to do the x-ray.

(Awngshayi, Interview 1)

Drawing on both biomedical and immigration discourses, when she was instructed to undergo yet another chest x-ray prior to her appointment at the TB clinic, Awngshayi refused:
So then, [at the TB clinic they] want to do the x-ray again! I said “noooo way!” I just did it the x-ray with my family doctor in that clinic! I [told them I] don’t want to do the x-ray now. (Awngshayi, Interview 1)

As Awngshayi went on to explain, her refusal to follow clinic procedures was met with force from the administrative staff and she was given an ultimatum – she had to either take an x-ray or she would not be assessed by the specialists: “I had the long argument with the [woman]. [She said to me,] ‘You want to see the doctor? You better go to the-- you know, x-ray’. I have to listen to her!” (Awngshayi, Interview 1). In the end, Awngshayi said she “managed” the situation by negotiating with the x-ray technician and explaining why she did not consent to undergoing the procedure. Eventually, the participant was permitted to undergo the medical assessment without an x-ray. After speaking with the staff physician, she was granted an exception under the condition that she would provide a copy of her most recent x-ray during the follow-up visit.

As the previous example indicates, patients did not have many options for successfully resisting the procedures of taking an x-ray. They could, however, challenge clinicians’ interpretations of these images. In an attempt to construct herself as not ‘dangerous’ or ‘at risk’, Margaret challenged the clinician’s assertion that the abnormality on her chest x-ray was indicative of LTBI:

Physician: So the first thing is, I had a look at your x-ray. [Margaret: mhm] I understand that you [did karate] [as a child]? [Margaret: mhm] You do have an abnormality on your x-ray. It’s-it’s not on your rib, actually. So--
Margaret: --It’s a scarring from [the rib fracture].
Physician: Well, it-it doesn’t lie on any of your ribs. [Margaret: okay] It’s actually in between your ribs but, um, so, you know, again, you may have had an old exposure, [Margaret: No] I don’t know exactly what that is--
Margaret: I’ve never had— (Margaret, shaking her head “no”)
Husband: --Just-just let him finish.
Physician: So, yeah. I’m just saying, ah, whether--, you know, a lot of people are exposed to TB; they don’t necessarily have any recollection of the exposure. I’m not gonna try and judge anything; I’m just telling you that there is an abnormality on your x-ray…

(Margaret, Observation)

Margaret’s conduct not only describes resistance (by rejecting the physician’s interpretation of her x-ray, and by interrupting him during the encounter), but also active participation. By taking up biomedical discourses and offering an alternative interpretation (positing that the abnormality
was evidence of an old sports injury – a rib fracture), Margaret actively participated by attempting to (albeit unconvincingly) construct herself as a ‘healthy’ subject.

Given that patients had little options for resisting clinic procedures, the remainder of participants did not oppose instructions to produce medical images. On the contrary, at the request of clinic staff, participants were willing to go to great lengths to provide TB clinicians with additional images taken over the course of their immigration health screening (David, Zara, Awngshayi). In this way, immigration TB patients actively took part in providing clinicians with the necessary information to construct their risk profile and subsequent diagnosis. Considering that a diagnosis was necessary for obtaining medical clearance, compliance with clinic procedures and physicians’ instructions was consistent with participants’ objectives.

5.2.2 “Let me ask you a few more questions”: Participating in the Clinical Interview

During the initial visit, after the reason for the patient’s appointment has been established, the clinician proceeds to interview the patient. Following a set of standardized questions, the clinician elicits the patient to recount her social (i.e. current and past housing conditions, travel history, place of birth, time since arrival in Canada, etc.), behavioural (i.e. engaging in behaviours considered to put the individual at an increased risk of TB or HIV infection) and health (i.e. previous TB infection, overall health history, symptoms of active TB disease, etc.) history. The clinician is guided through this process by following a standardized “Initial Assessment” form. After interpreting the patient’s accounts through a biomedical lens, the assessing physician documents all clinically relevant information and uses it to construct the patient’s risk profile.

Other than Margaret (who exhibited recalcitrant behaviour throughout the entire appointment out of frustration with the immigration process), participants did not resist the clinical interview. They actively answered all questions asked to the best of their ability, elaborating and providing explanations whenever uncertainties arose:

Clinician: Okay, okay. Ah, and any problems with your kidneys, that you know of?
Jergua: …I don’t know. Ah, it’s a painful here sometimes.
Clinician: Okay, okay. Ah, a-and your liver?
Jergua: …I dunno.
Clinician: No-no? Okay. Ah--
Jergua: --It’s, ah-h-h- when I go to the doctor, they examine my kidney with ultrasound. It’s normal.
Clinician: Good, good. Ah, and … you don’t have diabetes?
Jergua: …I don’t know.
Clinician: No. Okay.
Jergua: Because I did not examine.
Clinician: Right. Okay. Okay. …

(Jergua, Observation)

During analysis, it became clear that there are limits to a patient’s ability in co-constructing their risk profile. A substantial level of health literacy is required for patients to accurately answer some questions asked during the clinical interview (i.e. about past illnesses, particularly TB and details about treatment regimens). When the biomedical knowledge to answer ‘accurately’ was lacking, the assessing clinician may be able to circumvent that through physical examination of the patient. For instance, when Jergua was asked whether he had ever received a BCG vaccine, instead of allowing him to answer the question, the clinician decided to look for physical evidence of the vaccine (a scar on his upper arm) instead. In other instances, some participants came up with more creative and unexpected solutions to provide the information sought out by clinic staff:

Nurse: Did you do a skin test?
Fiona: Yes.
Nurse: Was it big?
Fiona: I took a picture. (Fiona reaches for her phone and begins looking for the picture of her skin test.)
Nurse: Did the doctor read it or just see the picture?
Fiona: He read [it]
Nurse: Oh, he did it.
Fiona: Yeah. Wait. (Fiona instructs the nurse to wait while she searches through her telephone camera roll.)
Nurse: You took a picture. Lovely.
Fiona: Yeah, because I said to my boyfriend “This is my (laughs) result.” (Fiona continues searching. After a while, she cannot find it and is ready to give up.) No.
Nurse: No? When he did it, was it flat, or was there a bump?
Fiona: Flat, but started [to get] bigger because they put the, circle-the [Nurse: pen?] pen. Then, yeah. The red is bigger, but flat.
Nurse: Flat. Okay, I’ve got it. Thank you.
These examples demonstrate that while clinicians were in control of constructing patients as specific types of subjects, participants took an active role in their co-construction as medical subjects. The fact that only a few instances of resistance were observed among study participants during the construction of the patient’s risk profile (and subsequent diagnosis) suggests that compliance with institutional practices and procedures was perceived by immigration TB patients as beneficial in the context of immigration; without a medical assessment, a diagnosis ruling out active TB cannot be made, and medical clearance cannot be obtained. As such, participants were motivated to provide all information necessary to make this diagnosis.

While ultimately motivated by the desire to obtain medical clearance for the purpose of immigration, participants took up biomedical discourses to not only comply and actively partake in the construction of their risk profile, but also to resist being constructed as infected and thus ‘dangerous’. Having said that, however, these findings suggest that in some cases patients’ non-compliance with clinical procedures in the context of IMS may actually be informed by biomedical logic reflecting the newcomer’s concern for their own health and wellbeing, and that these concerns may be a direct result of patients’ experiences during the immigration and settlement process.

5.3 “Doing nothing is not a great option”: Negotiating Prophylaxis

5.3.1 “Tell them the options. It’s not all on us”: Establishing a Plan of Care

The most explicit and recurring instances of resistance during the medical encounter were observed in the context of establishing a plan of care. A plan of care is decided after active TB has been ruled out and other diagnoses have been made. Given that this diagnosis satisfies CIC requirements, any other therapeutic decisions are optional for IMS patients. Furthermore, in contrast to the compulsory aspects of the medical encounter (x-rays, clinical interview, physical
examination, sputum induction, etc.), no particular course of action is imposed on the patient nor decided solely by clinic staff; rather, it is established in collaboration with the patient. Patients are educated on the biomedical model of TB; they are presented with medical advice and available options for moving forward, and are expected to readily take on the responsibility of making decisions about their potential treatment and health.

The most common course of action presented to TB patients in the context of immigration medical screening was preventative treatment for LTBI. In the following section, I describe the strategies used by study participants to negotiate prophylaxis at the TB clinic.

5.3.2 “If you can, try to sell preventative treatment”: Clinicians’ Preference for Prophylaxis

After analyzing clinic data, it became apparent that clinicians had a preference for prophylactic treatment. Given the current body of knowledge, clinicians “can’t predict exactly when [LTBI is] gonna activate in all people. [I]t can activate anywhere, any time in any-one, and [medical experts] still, despite the years of experience with this disease, [they] still can’t pinpoint those people” (physician to John, Observation 1). TB specialists’ attitude favouring a curative approach to TB prevention is thus in part founded on the medical ethic of care (concern for the health and wellbeing of the individual patient), a commitment to public health principles (to prevent or limit the possibility for transmission of TB to others), as well the limitations of biomedical knowledge (i.e. uncertainties about the underlying mechanism responsible for reactivation of LTBI).

As a precaution, TB clinicians generally advocated that patients with LTBI consider preventative treatment. For some groups of patients, however, particularly those biomedically constructed as ‘high risk’ for reactivation (including new immigrants), clinicians engaged in strategies with the intention of persuading patients to ‘choose’ prophylaxis in hopes of preventing future cases of active TB disease. This was explicit in clinicians’ instructions to residents (“If you can, try to sell preventative treatment” [field notes, Feb. 2016]), and implicit through clinicians’ expressed approval of patients who decided to start prophylaxis (e.g. after learning that Fiona accepted prophylaxis, the clinician praised her for having made a good decision and being “Very, very smart!” [Fiona, Observation]).
5.3.3 “…for your own health”: Health Education & Prophylaxis as Optional for IMS Patients

In the context of immigration, prophylaxis was always introduced to patients as a choice. Clinicians made an explicit distinction between the compulsory immigration component of the medical assessment and the voluntary nature of preventative treatment of LTBI. During the follow-up visit, once active TB disease was ruled out, participants were informed that “from an immigration standpoint, [IMS is] all done” (physician, Memphis Observation); any discussion of treatment options and the patient’s decision to accept or refuse prophylaxis was discursively framed as being in the interest of “[their] own health”. Despite being presented as optional, some participants perceived clinicians’ conduct as coercive. One participant, Memphis, explicitly commented on this during our interaction: “They said I have a choice to treat it [LTBI] but they keep telling me about it and telling me it’s there, so I feel like I don’t really have a choice”.

Health education was a salient component of the conversation about prophylaxis. Underpinned by biomedical logic, TB clinic staff framed prophylactic treatment in terms of the health risks and benefits this therapy presented to patients. In addition to merely being a method of transferring knowledge from medical experts to patients, health education was used strategically at the TB clinic to try to convince patients to accept clinicians’ advice, particularly with regard to starting prophylaxis:

Clinician: Do you remember the difference between active and latent TB, or no?
Sunny: Yeah, I think, ah, the germs are still alive (smiles) and, ah, and ---
Clinician: You’ve got it! (both laugh) Yes! And the latent form?
Sunny: It’s, like, the type--., it can come to life, like, any time, you know?
Clinician: Excellent! That’s exactly it.
Sunny: So, I have something dead.
Clinician: Yes, we believe you have something dead in there. (laughs; touches Sunny’s knee)
Sunny: But it won’t come to life, I-- (laughs)
Clinician: Well, this is what we’re hoping. So, what we can do – and this only preventative and it’s up to you; there’s no immigration need, no, but this is just for your own health – we would like-- … you had at TB skin test done one time, is that correct?
Sunny: Yes.
Clinician: And it was negative?
Sunny: Negative.
Clinician: So, we’d like to-if you would like to, we would to do another TB skin test.
Sunny: I don’t want to do it again and again.
Clinician: Okay, that’s fine.
Sunny: It’s painful, you know? There was a big blue mark on my-, forearm, (points to his forearm) see?
Clinician: That’s fine. So, the reason we would do another TB skin test is to determine, for sure, did you pick up something when you were living abroad. And if you do have the dead bugs in your lungs, would you like to treat-would you like us to treat it? … So, one thing ---
Sunny: I think they’re happy in there, so they don’t want to get alive here.
Clinician: Okay, that’s totally fine. So, as you know, um, I don’t know if they went through it last time – just let me talk, and then you can tell me “no” … (Clinician laughs, touches Sunny’s shoulder playfully, and continues to explain LTBI and how prophylaxis works).

(Sunny, Observation)

In the above example, the clinician is shown to first establish the patient’s health literacy, then tailor health education to the patient’s level of knowledge regarding TB. The clinician’s objective – to persuade the patient to seriously consider prophylaxis – is clear; despite being acknowledged, the patient’s initial refusal to continue with diagnostic testing and potential treatment of LTBI was ignored by the clinician. Sunny’s reason for refusing further investigations (e.g. previous negative experience with the test) was dismissed, and the clinician continued to educate the patient in hopes that he would change his mind after considering the scientific facts about TB infection and its treatment. The clinician’s explicit statement for the patient to “just let me talk and then you can tell me ‘no’” demonstrates that while patients have the right to refuse treatment, they cannot refuse health education during their appointment.

As I will go on to show in the remaining sections, despite clinicians’ attempts to guide patients’ therapeutic decisions primarily according to biomedical logic, most immigration TB patients in this study interpreted this information in the context of the immigration and settlement process. Below, I present the strategies employed by immigration TB patients to negotiate prophylaxis.

5.3.4 Accepting Prophylaxis

In this study, two participants (Fiona and Eve) decided to prophylactically treat their LTBI. Neither Fiona nor Eve required persuasion; both participants readily expressed their desire to begin preventative treatment and complied and actively participated in the encounters by taking up biomedical discourses. Their therapeutic decisions, however, were guided by different logics: while Eve perceived prophylaxis as a rational and logical choice for her health, Fiona’s decision
was primarily informed by immigration logic. While Fiona was in Canada legally, at the time of IMS she did not have a valid work permit. As she later explained during the research interview, she opted for preventative treatment out of fear that an untreated LTBI diagnosis may be a barrier to obtaining permanent residency in the future. Despite this rationale behind her decision, Fiona participated in the TB clinic within the biomedical frame of knowledge. She complied with clinicians’ instructions and remained actively engaged, asking only health-related questions.

In contrast to Fiona, after clarifying that preventative treatment would have no bearing on her CIC application, Eve decided to start treatment. Like Fiona, given that her underlying objectives aligned with those of health professionals, she eagerly complied with clinicians’ instructions. There was an instance, however, when Eve exercised her power as a patient, taking up the logic of medicine in pursuit of her objective: to begin treatment as soon as possible. Eve was diagnosed with LTBI several days before her birthday. Because patients are instructed to abstain from alcohol over the course of treatment, she was given the option to delay starting prophylaxis until after her birthday: “I was happy to offer to say, if you want to wait [to start treatment] until after your birthday we could do that, but that’s up to you, okay?” (physician to Eve, Observation 1). As she later explained during her research interview, Eve did not want to wait and demanded that her treatment start sooner:

No, no, no, no, no. When I set my mind on something, I need to do it. And ever since they told me [my LTBI] was treatable, I'm like, “okay, yeah. I'm just going to treat it. I just want to be done with it.” I don't see why I should wait because, anyway, there's always going to be something. Like, it's okay; just it's my birthday. I don't need to drink alcohol for that. I mean, I can, you know, I can go nine months without it; I'm going to be totally fine. I'd rather do it right away, so then in nine months I’m free, you know? I don't have to be worried about it anymore. I can just-, go on with my life.” (Eve, Interview)

Eve perceived LTBI as a risk to her health and a source of stress. From this perspective, while preventative treatment was considered somewhat burdensome, it was a necessary means to achieving optimal health and peace of mind. While TB medical testing was a compulsory part of the immigration process, it provided Eve the opportunity to uncover a hidden danger to her health. Unlike many other participants in this study, her attitude reflected the extent to which biomedical logic governed her conduct in the context of the TB clinic encounter as well as day to day life. The instance at the clinic described above demonstrates that some immigration TB patients may use the TB clinic encounter to exercise their right to prompt access to medical care.
5.3.5 Rejecting Prophylaxis

The majority of study participants who qualified for preventative treatment (Angela, Jane, Sunny, and Memphis) refused. While most considered the implications of pharmacotherapy on their health, their reasoning for rejecting treatment was influenced by their immigration process. Angela, an international student, was diagnosed with LTBI. The assessing physician, a resident with seemingly limited knowledge of the immigration process, recommended that Angela start prophylaxis. Given her temporary resident status and her upcoming return to China, she took up discourses of biomedicine and immigration to consider prophylactic treatment and engage the clinician:

Angela: [via interpreter]... my treatment requires 9 months to treat the inactive TB, however I can only stay here for 2 to 3 months and I was wondering if there are other treatment options?

[...]
Resident: Yeah, I know, and that’s-that’s what I was trying to figure out as well. Yeah, the thing is you can also receive some of your treatment in China...if-if you wanted to. Uh, it’s completely-now first of all, this is completely your decision. It’s up to you whether or not you want to treat it. The whole purpose of it is giving you the choice. You can even have this treatment while you’re in China. Okay? But the whole point of giving you this treatment is to lower the risk. Now if there is some problem with us giving you the treatment for two months and then you have to go to China for seven months and getting the medication, then we may just advise you just maybe to go back to China, and to start prophylaxis treatment there-get seen by a TB doctor there. Okay?

[...]
Angela: [via interpreter] If I get the treatment back in China, and lets say when I return to Canada 2 to 3 years later, I will not need to go through the treatment? Will they recognize the treatment I received in China? [Angela, Observation]

The above excerpt demonstrates that for some IMS patients, the option of preventative treatment may be complicated by their migration journey. In Angela’s case, as a temporary resident, she was logistically unable to comply with the recommended plan of care as she would not be living in Canada for the duration of time required to complete the entire course of treatment. When the resident recommended she undergo prophylaxis in China, Angela’s primary concern was whether this treatment would be considered valid by Canadian standards. In the end, Angela was
counseled by the staff physician that at this point in time, prophylaxis was not a practical option for her; he advised the patient to be wary of signs of active TB disease and instructed her to contact the TB clinic for another assessment when she returns to Canada in the future.

While Angela did not have the opportunity to refuse the option of preventative treatment, Sunny, Jane, and Memphis did. For Sunny and Jane, prophylaxis was not a desirable option. Both participants were frustrated with the immigration process and, as explained in the previous chapters, they both regarded immigration health screening as an inconvenience and a barrier to obtaining their immigration status. As described above in section 5.3.3, Sunny’s initial attempt at resisting the clinician failed because the clinician had not yet finished the teaching. After that incident, Sunny actively engaged the clinician by taking up biomedical discourses and asking questions about the risk of side effects and clarifying details about the treatment regimen. Despite asking health-related questions, Sunny repeatedly expressed his concern that starting prophylaxis will be perceived by CIC as indicative of a dangerous health condition resulting in the withholding of medical clearance:

Sunny: But my immigration things are all done? Like, the file is closed? Or, like— … Because in case, like, all the things were clear, and again I did something and it went against it [Clinician: yeah], and again my file is open, and I’m still, like, doing same thing again for the-- … So, [medical surveillance] is done?

Clinician: Yeah. Well, as soon as I’ve done--

Sunny: --So, it won’t affect anything?

Clinician: No. Preventative treatment doesn’t affect your immigration. All immigration cares about is: do you have active disease. Do you have active disease? No.

(Sunny, Observation)

His concern over the status of his CIC file was Sunny’s true motivation for not pursuing preventative treatment (this was confirmed during the research interview). He tried to negotiate the course of action for confirming the LTBI diagnosis, asking whether it was possible for the TB clinic staff to refer to the results of his previous test conducted for immigration purposes and explained that given his experience with the immigration process, he did not want to undergo testing for the third time. Towards the end of the encounter, after repeatedly being presented with
facts about LTBI and prophylaxis, Sunny became defensive and felt it necessary to justify his decision to both the assessing clinician and the respirologist:

Sunny: I have your card, like, just in case I need some time before--
Clinician: Of course! There is no rush!
Sunny: --because, again, I have to do, like, my CIC file is closed to--
Clinician: That’s fine (whispers).
Sunny: It’s-it’s a big headache, you know? Like, I have to--, I have done [testing] in India, so they told me that ‘you have to do it again in’, ah --
Clinician: In Canada. That’s right.
Sunny: -- Canada. So, once I’m done with [immigration surveillance], I’m satisfied [Clinician: everything’s fine] that everything is good, then I-then I-I’ll think that I will move forward --
Clinician: Yes, no problem. [Sunny: or--] and there is no pressure. From us.
Sunny: Then I’ll do it—
Clinician: --Okay!
Sunny: No, I want to cure my--like, if I’m infected, I need to get rid of those--
Clinician: --You just have other things that you need to do right now.
Sunny: Yeah. Like, I’m concerned, like, I-I have to get medication and I just want to cure my disease, but I [don’t have active TB], but the cells are dead, but I-I want to be pretty sure that--I get rid of them.
Clinician: Sure.
Sunny: So, but first I-my first concern is, like, I want CIC guys-- [Clinician: the immigration stuff] --immigration guys [Clinician: that’s fine!] to give me a [clearance]. Once I’m, satisfied with that, then I can—
Clinician: --then you can call me back. So, nice to see you! [Sunny: thank you] I will see you in six months [for the follow-up visit], or maybe sooner.
Sunny: Thank you very much. (Sunny, Observation)

When Sunny perceived that his rationale for declining the recommended treatment plan was met with moralizing judgments from the clinician, Sunny, once again, took up biomedical discourses, positioning himself as a ‘responsible patient’; he assured the clinician that he wants to “cure [his] disease”, but argued that his immigration file must take priority over his health for now. The clinician, however, responded dismissively. Sunny was instructed to return to the clinic for further surveillance in 6 months time, or sooner if he decided to start preventative treatment.

Jane employed a similar strategy to Sunny in negotiating prophylaxis, alternating between both biomedical and immigration discourses. In line with the physician’s approach, she engaged in the conversation using medical logic, demonstrating that she considered the risks and benefits of preventative treatment on her health: “Well, it just seems that the treatment is more harmful than
the alternative (Jane says, laughing)” (Jane, Observation 2). After the biomedical aspects of prophylaxis were sufficiently addressed during the encounter, Jane asked the physician about the effects of her therapeutic decision on her CIC application:

Jane: So, I guess…either option…I guess I just wanna know if that changes anything on my permanent residency application— (Jane says, raising her hands in a gesture of surrender)

Physician: No.

Jane: Does it delay anything?

Physician: No.

Jane: Okay. (Jane scoffs)

Physician: The fact that you don’t have active TB, that’s all they care [about].

Jane: Okay, great!

Physician: [If] you don’t have active TB, they say, “don’t worry about it, you don’t have to be on treatment.” [Jane: Mhm] And what we’re talking about right now is outside of that application, it’s, um…Just--

Jane: --for, my health.

Physician: Yeah. (Jane, Observation 2)

Having been assured that her decision has no bearing on the immigration process, the physician’s response implicitly compels Jane to allow biomedical logic, rather than immigration, to inform her decision. At this point, Jane has already made her decision – she does not want to start prophylaxis – but she perceives that in order for her argument to be accepted as legitimate, she must provide the doctor with a medically relevant justification:

Jane: Um…I would…w-wait on that (Jane laughs nervously) [Physician: That’s okay] because I’ve been…living in Canada where it’s not as present I guess [Dr: Yeah] as it would be-- if I lived … back home, so--

Physician: But just to be clear, the fact that you have some changes in your x-ray could mean that you were already exposed.

Jane: Yeah.

Physician: So the fact that you’ve moved here doesn’t really change a whole lot; [Jane: Oh yeah, yeah] it means that you were probably exposed and you may already have that bacteria there [Jane: Mhm] and it is possible for that, um--

Jane: --to flare up.

Physician: --to flare up. Exactly. (Jane, Observation 2)
While she framed her argument using biomedical discourses, her understanding of TB was medically inaccurate and thus was not accepted as a valid argument by the physician. Jane continued to engage in the conversation and explore the potential consequences of LTBI on her health, with the help of her sister (who is also a physician). In the end, after all potential outcomes were discussed, Jane returned to the issue most pressing to her: immigration.

Physician: You prefer to kind of leave things and then?
Physician: That’s fine. [Jane: Yeah] That’s fine.

(Jane, Observation 2)

Once all potential clinically relevant outcomes and scenarios (i.e. alternative diagnoses, potential factors leading to LTBI reactivation, risks and benefits of preventative treatment, risks and benefits of declining treatment, ongoing medical surveillance, etc.) were discussed with the patient, Jane was finally permitted to decline prophylaxis; her decision was accepted by the clinician, irrespective of the actual underlying logic informing it.

Jane and Sunny’s encounters demonstrate that while clinicians may not personally agree with patients’ therapeutic choices, they understand that patients’ individual life circumstances (including immigration and settlement challenges) may be most salient to their decision making process around preventative treatment. Although clinicians must respect their patients’ autonomy, the clinicians only come to a point where they “agree to disagree” once the patient has successfully demonstrated the consideration all available options information through the traditional biomedical model.

While Jane and Sunny struggled to exercise power during the medical encounter, Memphis was more successful. To her, prophylaxis was a desirable option, but given her settlement challenges and other, more pressing health concerns, Memphis had to delay starting treatment. Although she did express her concern about the implications of treatment (or refusal of treatment) for CIC and emphasized the challenge of attending clinic appointments over the course of treatment as a new immigrant, Memphis approached the conversation as not only an engaged patient, but also, and more importantly, one willing to comply with medical advice:
Memphis: So, if I were to start, *when* exactly do I have to [come to the TB clinic]? Like, in the morning[s]? … ‘Cause right now [I’m taking time] off work.

Clinician: I know, it’s a big commitment.

Memphis: I’m struggling [working] two jobs, yeah.

Clinician: *I know!* And that’s a real thing. Unfortunately, we’re only allowed to open [certain weekday] *mornings*. [Memphis: okay] … That’s only our allocation as a specialists’ office. So –

Memphis: So, even if I don’t take this, like, medicine program, will it affect my—

Clinician: Immigration?

Memphis: Mhm.

Clinician: No.

Memphis: But *then*, it’s just gonna be *there*, and I’m gonna have to think about it.

Clinician: That’s true. But the truth is – I’ll be very honest – in my experience, no matter what, even if you take the medication, that scarring in your lung will probably be with you forever.

Memphis: So –

Clinician: It won’t change [Memphis: the scar?] how your x-ray looks. Correct.

Memphis: Okay. But I-I still—it’s—, there’s a part of me that doesn’t want it there – I mean, the germ.

Clinician: *I know.*

(Memphis, Observation)

Despite ultimately making the same decision as the other participants (rejecting prophylaxis), in this encounter, the clinician did not respond with the same amount of pushback as observed with the others participants. The likely explanation for this lies in the alignment of values between the health care provider and the patient: with Sunny and Jane, the clinicians had to try and *convince* the patients that prophylaxis was desirable; this was not necessary with Memphis as she already viewed preventative treatment as a favourable option. It is interesting to note, however, that just because a patient *claims* to have a desire to start preventative treatment in the future does not necessarily mean that they actually intend to do so. Although Memphis confirmed during the research interview that her desire to undergo prophylaxis was genuine, Jane, despite implying that she may consider preventative treatment after her immigration application process is complete (‘I think for now I’ll wait, just ‘cause I have a lot of other stuff…priority list-wise’”), admitted to me that she had no intention to undergo 9 months of treatment for a latent, asymptomatic infection. These findings indicate that clinicians are more likely to accept patient’s decisions to refuse treatment and regard immigration and settlement conditions as a legitimate reason for their refusal so long as patients demonstrate that their views on *health* align with medical logic. Alternatively, from the perspective of the patient, it can be stated that framing
prophylaxis as a desirable (irrespective of whether this is genuine or fabricated) yet not practical option is an effective strategy of resistance for patients during the TB clinic medical encounter.

6 Chapter Summary

In this chapter, I presented the findings that address the second part (part B) of the second research question, which asks *How do immigrants undergoing TB surveillance negotiate power throughout the different stages of the immigration and settlement process during the Canadian TB clinic encounters?* I began this chapter by discursively locating the TB clinic at the intersection of Immigration, Public Health, and Medicine. I asserted that the intersection of these competing logics shape the discursive context and power relations of the doctor-patient encounter, and implicate IMS TB patients and TB clinicians in a complex web of power. Having described the clinic setting, I explained that biomedical logic is the dominant logic that operates at the site of the TB clinic, informing the conduct and practices of clinicians. This logic shapes the construction of TB patients as medical ‘cases’ and informs the clinical management of patients, which ultimately limits the possibilities of resistance and exercise of power by immigrant patients. Using observation data, I have described the strategies used by participants to negotiate the TB clinic encounter, showing how participants resisted and actively participated in establishing immigration as the reason for the appointment, co-constructing their own risk profile, and negotiating prophylaxis. These results show that for the most part, due to the compulsory nature of the IMS medical assessment for CIC purposes, there is little opportunity for IMS TB patients to resist power. The only time resistance was possible and acceptable was in making therapeutic decisions about the potential treatment of LTBI.

In the last and final chapter, I discuss the study findings through the theoretical lens of governmentality, focusing on the concepts of discourse, subjectivity, biopower, and biocitizenship.
Chapter 8
Discussion

“From the cradle to the grave, people are classified, shaped and ordered according to policies, but they may have little consciousness of or control over the processes at work.”
(Shore & Wright, 1997, p. 4)

1 Introduction

The results of this study reveal that the immigration and settlement process in Canada, particularly as it relates to immigration medical testing and tuberculosis (TB) surveillance, is much more complex than it is made to appear in official policy documents and guidelines. While bureaucratically the process of immigration may be perceived as a neat chronological progression of sequential steps, in reality, at the procedural level, the integration of medicine and public health and the involvement of various medical and public health experts and officials in meeting immigration application requirements complicates and often derails the process of obtaining immigration status for many applicants. Through the reconstruction of both participants’ immigration experiences and immigration policy as Migratory Pathways, it was possible to examine the procedural components that shape both the immigration and settlement, and immigration medical surveillance (IMS) processes for newcomers under suspicion of TB infection.

Participants described the immigration and settlement process as a period of unusual physical and psychosocial stress; they often became victims of a broken (or inefficient) system, frequently incurring significant and unanticipated losses of both time and money. Moreover, the problems arising from the selective integration of medicine and public health into the immigration process have had significant effects on the social and economic immigration and settlement experience of new immigrants. As participants moved through the different stages of the Migratory Pathway – from the initiation of the Citizenship and Immigration Canada (CIC) application, completing the Immigration Medical Exam (IME) including the TB Furtherance process, obtaining IME clearance, submitting the complete CIC application, receiving CIC approval and the
simultaneous referral for immigration medical surveillance (IMS) for TB, arrival in Canada, contacting Public Health officials, undergoing medical assessment for TB IMS, to finally obtaining post-landing medical clearance – they encountered a number of health care providers, public health practitioners, immigration agents, and border authorities; these encounters required the exercise and negotiation of power. The results of this analysis further suggest that the construction of immigrants undergoing TB immigration medical screening and surveillance as ‘dangerous’ and ‘risky’ subjects during these encounters influenced the ways in which participants perceived their health and themselves, and, in effect, shaped their conduct during the immigration process both abroad and in Canada.

The discussion presented in this chapter is divided into three sections. The first section considers the effects of discursively constructing immigrants as various types of subjects on the conduct of immigration applicants and new immigrants during the immigration and settlement and medical surveillance processes. In the second section, I argue that in the context of immigration, the TB clinic functions as a political site for the transformation of foreign ‘others’ into biocitizens, highlighting the role of TB health care providers as indispensable to this process. In the third section, I problematize the TB immigration medical surveillance process and argue that while it presents an opportunity to provide medical care to new immigrants, the underlying objective of IMS as an immigration requirement and the authority afforded to biomedical knowledge as the regime of truth undermines the potential for these clinical encounters to address the underlying social and health needs of this vulnerable population.

2 The Construction & Contestation of Subjectivities

The intersection of immigration policy, public health policy, and medical and clinical standards of practice around TB forms the context for the interpretation of the study findings. Viewed through the framework of governmentality, policies can be conceptualized as discourses as they “reflect the rationality and assumptions prevalent at the time of their creation” (Shore & Wright, 2011, p. 3). The results of this study, as presented in Chapters 6 and 7, suggest that the practices and behaviours of various experts encountered by participants throughout the immigration and medical surveillance processes are not only directly informed by policy guidelines, but are also shaped by underlying logics and implicit assumptions embedded within certain regimes of
knowledge. In effect, the discourses of policy not only construct the subject and object of power, but also define the power relations between the subject and the expert.

The categories and the corresponding social roles of immigrants as subjects varied between different sites along the Migratory Pathway according to the ways in which different rationalities of governance and regimes of knowledge and power articulate, overlap, conflict, and reinforce each other. From the moment the CIC application process is initiated, new immigrants to Canada are constructed as various kinds of subjects through both repressive (disciplinary power) and productive (biopower) forms of power. As immigrants move along the Migratory Pathway, these subjectivities continue to be constituted and reconstituted in relation to the ‘pathway setter’ (the medical expert) and in accordance with the specific policies operating at a particular stage in the immigration and settlement process. The effect of the dynamic nature of the immigration and settlement process was that participants had to (sometimes simultaneously) occupy multiple subject positions. Specifically, at the initiation of the application process, participants were constructed as ‘applicants’ (in relation to CIC); during the IME, while they remained an ‘applicant’ to CIC, they simultaneously became ‘the client’ in relation to the Panel Physician (PP); during the TB Furtherance process, they became ‘the patient’ to the TB specialist; once CIC approval was obtained, the ‘applicant’ became either a temporary or a permanent resident; once they were referred for IMS, they simultaneously became both a ‘client’ to public health authorities and, once again during the IMS medical assessment, a ‘patient’ in relation to TB specialists. As a result, I argue that through strategic compliance with, resistance to, and exercise of power, participants challenged the system and actively participated in their own constitution as specific subjects as a means of reaching their ultimate objective – to obtain secure immigration status.

2.1 Intersecting Policies: The Medicalization of Immigration

The immigration process is an administrative apparatus used to regulate the movement of people across borders. Its primary function is to exclude undesirable subjects and permit entry to those whom the state deems ‘desirable’. While the state ultimately defines which criteria constitute a foreign subject as a ‘threat’, it relies on diverse forms of knowledge and expertise to collect such information about applicants relevant to the selection process.
The medicalization of immigration places the bodies of hopeful ‘foreign’ applicants “under a medical mandate [which] exposes them to scrutiny, to documentation and to description in medical terms” (Rose, 1994, p. 58). This provides a link between the rationality of the modern biopolitical state – i.e. the defense of society – and public health discourses; through the practice of immigration health screening, the state brings ‘foreign’ bodies under its controlling gaze, which, through medical surveillance and discipline, allows for their management and control to not only monitor and minimize the potential ‘threat’ of contagion, but also to maximize their usefulness and economic potential as new citizens.

The state has adopted public health principles and incorporated medical criteria to classify and appraise immigration applicants according to their health status. The articulation of immigration and biomedical discourses and policies results in a focus on the prevention of importation of certain diseases deemed to either be too ‘costly’ for the state (Bisaillon, 2011), or, as in the case of TB, posing too great a risk to the health of society (Horner, 2016; Horner et al., 2013). From this perspective, TB ceases to be regarded merely as a personal and public health issue, and infected individuals are no longer constructed as a risk to themselves and their communities; by discursively transforming TB into an issue of biosecurity, immigration applicants with TB infection now constitute a ‘threat’ and a ‘danger’ to the entire nation (Horner et al., 2013). This discursive construction not only frames TB as a constant exogenous threat, but also shapes social perceptions of immigrants as ‘importers of disease’ (Horner, 2016). Similarly to what has been found by Horner (2016), this study suggests that the ways in which the foreign ‘other’ is discursively constructed through this process has significant social and material implications for immigration applicants. More importantly, however, the overlap of the competing logics that underpin immigration, public health, and medical discourses about ‘immigrant TB’ not only shape the organizational structure of the Migratory Pathway, but also informs the ways in which power functions at the micro-level to govern the conduct of individuals during interpersonal encounters between applicants / newcomers and expert and authority figures.

### 2.2 Immigration Health Screening: Power, Purpose & Effects

My analysis of discourses and observations of practices related to immigration TB health screening throughout the immigration and settlement process reveals that all three forms of power – sovereign power, disciplinary power and biopower – simultaneously operate at the
intersection of immigration, public health, and medicine to monitor, identify, exclude, include, and discipline foreign ‘others’ according to their biology. These different forms of power produce different effects. The study results suggest that the immigration health screening and TB surveillance program serve four main functions in the government of new immigrants. These include: biological surveillance of ‘foreign’ populations, policing borders, monitoring and correcting deviant bodies, and producing subjectivities. In this section, I present and discuss the first three; the fourth – construction of subjectivities – is discussed in detail in the following section (Section 2.3).

2.2.1 Biological Surveillance of ‘Foreign’ Populations

The clinical encounter in the context of the IME serves as a technology of surveillance of foreign populations. Here, biopower operates under the field of biopolitics. Biopolitics is a regulatory technology of life

> which brings together the mass effects characteristic of a population, which tries to control the series of random events that can occur in a living mass, a technology which tries to predict the probability of those events…[and one] which aims to establish a sort of homeostasis…by achieving an overall equilibrium that protects the security of the whole from [in the case of immigration screening] external dangers”.

(Foucault, 2003, p. 249)

Immigration medical surveillance, as a “set of techniques used to implement biopolitics” (Puumeister, 2014, p. 301), is collectivizing. It is used to collect biomedical data (i.e. information about past health history, current health conditions, identify pathologies, particularly TB infection) from individuals to insert them and construct information about the larger social body (Puumeister, 2014). Discursively, this practice constructs the plural foreign ‘others’ and, in the case of Canadian immigration, informs the way that they are perceived in relation to Canadians. Scientifically, however, epidemiological surveillance of immigration applicants is used to better understand the movement of pathologies within the collective social fabric as opposed to concerning itself with its localization in the individual body (Armstrong, 1983, p. 18). As it specifically relates to TB, the practice of immigration health screening builds an understanding of entire groups in corporeal terms, and identifies the source of contagion at the level of the population (Lupton, 1995). As such, it can be argued that in the context of immigration, TB
medical health screening and surveillance enables and justifies the installation of security mechanisms (Foucault, 2003, p. 246).

The Canadian government has used information collected through global epidemiological surveillance to identify and discursively construct 146 ‘designated countries’ as countries with a high burden of TB. The Canadian government has used this data to implement policy mandating that all individual applicants who have resided in any of these countries must undergo a pre-departure IME to screen for TB in the name of biosecurity. Not only does this logic discursively pre-construct individuals from these populations as ‘risky’ and potentially infected prior to undergoing medical examination, but it also reveals that surveillance is a self-perpetuating process. Identification and statistical calculations of distribution of TB among ‘foreign others’ is used as proof that an external biological ‘threat’ exists; this logic, as argued by Lupton (1995, p. 25), provides legitimacy for further surveillance, discipline, and management of individual immigration applicants.

### 2.2.2 Policing of Borders & Exclusion of ‘Dangerous’ Foreign Bodies

Through border control, particularly the practice of policing and exclusion of those subjects considered to pose a threat to the security of the social body, it can be argued that immigration medical health screening functions as an apparatus of security. The medical encounter in the context of immigration health screening is a site for the deployment of sovereign power aimed to “filter ‘acceptable’ bodies from ‘threatening ones’” (Warren, 2013, p. 156) in the name of biosecurity. The cooption of biomedical rationality into immigration policies and the incorporation of the institution of medicine into the immigration process enable the state to utilize the authority of medicine and medical expertise to legitimize the exclusion of applicants based on their biological health. In this regard, biopower is expressed as anatomo-politics during the IME by acting on the individual through discipline “for the purposes of managing the corporeality of populations…within specific territories” (Holmer Nadesan, 2008, p. 8).

At this stage of the immigration and settlement process, the IME functions as a disciplinary mechanism. Through clinical examination of the individual body, CIC strategically uses the medical gaze to uncover unknown or hidden pathologies and deviances of the individual ‘foreign’ body (the applicant) through the use of medical technologies (i.e. x-rays, physical
examination, laboratory and clinical testing) and confession, making it transparent and visible to the gaze of immigration authorities. First, the medical gaze is deployed to identify and differentiate between ‘normal’, ‘dangerous’, and ‘risky’ bodies. Those who are ‘risky’ (e.g. those with non-contagious active TB disease and those with LTBI) are referred for IMS for post-arrival monitoring and management (see 2.2.3 below); those with active and contagious TB disease (pulmonary) are considered ‘dangerous’ and are deemed inadmissible until the source of contagion has been eliminated through treatment. The exclusion of the (‘dangerous’) individual applicant from the body politic based on their corporeality is the modern expression of sovereign power, which is “legislative, prohibitive and censoring” (Lilja & Vinthagen, 2014, p. 110). In order to be exercised, sovereign power requires a “mechanism of discipline” (Lilja & Vinthagen, 2014, p. 110) – in this case, immigration authorities – who are charged with exercising power by controlling the movement of bodies across geopolitical ‘sovereign borders’ (Warren, 2013).

2.2.3 Monitoring, Correcting & Transforming Foreign ‘Deviant’ Bodies

The immigration medical encounter (at both the IME and IMS stages) is a site where both biopower and disciplinary power operate to monitor, correct, and transform ‘deviant’ bodies (Armstrong, 1994, p. 21). In the context of immigration health screening and surveillance, the medical encounter functions as a technique of social control by acting on the population via the individual. As such, it is both individualizing and collectivizing.

During the IME, foreign bodies identified as ‘contaminated’ and ‘dangerous’ (individuals with active pulmonary TB disease) are ‘corrected’ through medical treatment before they become admissible and are permitted entry into Canada by state authorities. Those applicants identified as ‘risky’ (i.e. applicants with non-contagious forms of active TB, those with LTBI, or the formerly ‘dangerous’ but ‘corrected’ bodies) during the IME are referred for post-landing TB IMS. During the IMS medical encounter, ‘risky’ newcomers must repeat the medical examination to be, once again, ‘filtered’ into one of three categories: ‘risky’ (‘contaminated’), ‘dangerous’ (‘contaminating’), or normal. At this stage, deviant ‘contaminated’ bodies are ‘corrected’ through medical treatment to ensure that they do not constitute a ‘danger’ or ‘threat’ (i.e. ensure they are not ‘contaminating’) to Canadians; this is done by either providing medical treatment (correcting) to eliminate the source of ‘danger’ (TB infection), follow-up medical surveillance (monitoring) to clinically monitor the level or ‘risk’ or ‘danger’ by medical experts,
or through health education and health promotion to relocate surveillance from the clinic to the newcomer by inciting them to take up practices of self-care and self-surveillance (transformation). As I argue later (in Section 3), these functions are integral to the state citizenship project of transforming foreign ‘others’ into good biocitizens.

### 2.3 Immigration Health Screening & Surveillance: Constructing Subjectivities

Having discussed the first three functions of immigration screening and surveillance for TB, following French and Smith (2013) I argue that all these processes outlined above ultimately inform the discursive construction of immigration applicants and newcomers as specific subjects and produce individuality through the different disciplinary and monitoring techniques (Wallenstein, 2013, p. 11-12) operating during the immigration and settlement process.

Subjectivity is constructed through biopower, particularly through the production of knowledge about individual subjects. As knowledges about subjects carry underlying assumptions about the morality and moral worth of specific subject positions, they have “implications…for the construction of self-identity, or subjectivity” (Petersen & Lupton, 1996, p. 10). Defining norms and normality through various regimes of truth (discourses) acts on the desires of individuals, exhorting them to “voluntarily control themselves by self-imposing conformity” (Pylypa, 1998, p. 21) so that they may take up those subjectivities that best align with their personal goals and objectives. The concept of ‘health’ has become a powerful factor in the construction of subjectivities; it “has become a way of defining boundaries between Self and Other, constructing moral and social categories and binary oppositions around gender, social class, sexuality, race and ethnicity” (Lupton, 1995, p. 69) and, I would add to that list, immigration status. As it relates to the present study, in the context of immigration and settlement, categorizing migrants according to various ‘health’ categories has consequences for the ways in which they are constructed by CIC as applicants and immigrant subjects.

In this section, I describe the various ways in which newcomers are discursively constituted within biomedical and immigration discourses as both patients and applicants/newcomers, respectively. I argue that as applicants undergo immigration medical health screening and surveillance, they must negotiate between the subjectivities of being a successful applicant/desirable immigrant and a ‘good’ patient. While the expectations in conduct between these
subject positions at some points overlap, they also compete. Newcomers actively participate in the medical encounter as ‘good’ patients insofar as it aligns with their personal objectives and desires as migrants, which is, first and foremost, to become successful applicants and desirable immigrants with secure immigration status. Because immigration status is contingent upon obtaining immigration medical clearance for TB (i.e. an individual’s medical diagnosis directly affects which applicant / immigrant subject category the individual is placed in by CIC), this process ultimately affects the ways in which applicants and newcomers undergoing immigration medical screening and surveillance negotiate the medical encounter with TB specialists. Ultimately, in its effort to promote and produce ‘successful’ applicants and ‘desirable’ immigrants, the medicalization of immigration also produces ‘bad’ TB patients.

2.3.1 Medical Clearance: ‘Desirable’ Applicants & ‘Desirable’ Immigrants

In order to become a legal Canadian immigrant, immigration medical clearance is required before and, in some cases (as with TB) after arrival in Canada. The relationship between an individual’s medical diagnosis, their discursive construction within immigration discourses, their subjectivity as applicants / new immigrants, and the actions required of them as ‘desirable’ immigrants change as the immigrant moves along the Migratory Pathway (see Table 8.1). With regard to TB, as border policing aims to prevent the importation of infectious diseases, medical clearance during the IME stage requires proof that the applicant is not infected and does not pose a ‘danger’ to Canadians. After the results of the IME are known, those individuals deemed to be both ‘contaminated’ and ‘contaminating’ (as with active pulmonary TB) are constructed as ‘dangerous’ to the safety of Canadians; these applicants are ‘undesirable’ and are thus unsuccessful in obtaining CIC approval until the biological threat has been eliminated (e.g. once they complete a full course of therapy for active TB and are no longer ‘contaminating’ to others). Certain pathologies (such as non-infectious active TB, LTBI, or other) as well as signs indicative of pathologies (i.e. scar tissue from cured active TB) may imply that an applicant is ‘contaminated’ but they are not ‘contaminating’; they are discursively constructed as ‘risky’ but not ‘dangerous’. As such, while these individuals may not be ‘ideal’ or ‘desirable’ applicants (as these categories are only reserved for non-pathological bodies), they may be ‘acceptable’ applicants and thus can successfully obtain their immigration status. While ‘acceptable’ applicants become successful applicants and successful immigrants, in order to become
### Table 8.1  Construction of the Immigrant Subject Along the Migratory Pathway

<table>
<thead>
<tr>
<th>Migratory Pathway Stage</th>
<th>Medical Diagnosis</th>
<th>Discursive Construction</th>
<th>Applicant / Immigrant Subjectivity</th>
<th>CIC(^1) Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initiation of CIC Application</td>
<td>No diagnosis – Statistically identified as living in country with high TB burden (designated country)</td>
<td>‘risky’ and potentially ‘dangerous’</td>
<td>—</td>
<td>Referral for IME(^2)</td>
</tr>
<tr>
<td>IME</td>
<td>normal</td>
<td>‘healthy’</td>
<td>‘desirable’ ∴ successful applicant / immigrant</td>
<td>Medical Clearance; Approval of CIC application; full immigration status</td>
</tr>
<tr>
<td></td>
<td>abnormal chest x-ray</td>
<td>Potentially ‘contaminated’ / ‘dangerous’; Potential biological threat</td>
<td>‘undesirable’ applicant</td>
<td>Referral for TB furtherance</td>
</tr>
<tr>
<td>PRE-DEPARTURE (overseas applicants)</td>
<td>Infectious active TB (pulmonary)</td>
<td>‘contaminated’ &amp; ‘contaminating’ ∴ ‘dangerous’ (bio. threat)</td>
<td>‘undesirable’ ∴ unsuccessful applicant</td>
<td>Medically inadmissible; requires treatment &amp; follow-up (can reapply)</td>
</tr>
<tr>
<td></td>
<td>LTBI; non-infectious (or cured) active TB</td>
<td>‘contaminated’ but not ‘contaminating’ ∴ ‘risky’</td>
<td>‘acceptable’ ∴ successful applicant / immigrant</td>
<td>Pre-departure Medical Clearance; Approval of CIC application; referral for post-arrival IMS(^3)</td>
</tr>
<tr>
<td></td>
<td>Other pathologies (abnormal chest x-ray but no TB infection)</td>
<td>Not ‘contaminated’ but potentially ‘risky’</td>
<td>‘acceptable’ or ‘desirable’ ∴ successful applicant / immigrant</td>
<td></td>
</tr>
<tr>
<td>POST-ARRIVAL</td>
<td>Infectious active TB</td>
<td>‘contaminated’ &amp; ‘contaminating’ ∴ ‘dangerous’ (bio. threat)</td>
<td>‘undesirable’ immigrant</td>
<td>Medical Treatment; Follow-up with public health authorities</td>
</tr>
<tr>
<td></td>
<td>LTBI; non-infectious (or cured) active TB</td>
<td>‘contaminated’ but not ‘contaminating’ ∴ ‘risky’</td>
<td>‘acceptable’ (possibly ‘desirable’) immigrant</td>
<td>Risk management; medical surveillance; preventative treatment (optional); IMS Medical clearance &amp; full immigration status</td>
</tr>
<tr>
<td></td>
<td>other pathologies</td>
<td>Not ‘contaminating’</td>
<td></td>
<td>Medical clearance; full immigration status</td>
</tr>
</tbody>
</table>

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\(^1\) Citizenship and Immigration Canada  
\(^2\) Immigration Medical Exam  
\(^3\) Immigration Medical Surveillance
‘desirable’ immigrants they must obtain medical clearance once again by complying with TB IMS after arriving in Canada. According to participants’ perceptions, ‘desirable’ and ‘deserving’ immigrants are those who complied with all CIC requirements for pre-departure and post-arrival medical health screening and surveillance, and those who have managed and controlled their potential to ‘contaminate’ others by treating any active infectious TB disease.

2.3.2 Constructing Subjectivity Through Medical Diagnosis

The description above reveals the salience of medical diagnosis for producing subjectivities and governing conduct. In the context of immigration health screening, diagnosis is organizing: by identifying and classifying pathologies, it enables the categorization of applicants into ‘desirable’ and ‘undesirable’ applicant / immigrant groups. Among those applicants suspected of being potentially ‘contaminating’ through IME chest radiography, a specific diagnosis is required to determine whether the abnormality is due to TB infection and, if so, what type of TB infection (i.e. active pulmonary and ‘contaminating’ vs. latent and not ‘contaminating’). Diagnosis is also productive. Through discourse of norms and normality about what a successful / desirable (or at least acceptable) (and, by contrast, an unsuccessful / undesirable) immigration applicant and newcomer should be and should do, diagnosis in the context of immigration health screening informs the conduct of applicants and new immigrants. Defining the ‘healthy’ and uncontaminated body as the norm, any suspicion indicating that the applicant may pose a contagious threat (whether through statistical calculations at the level of a population, or health screening of the individual applicant) requires further thorough medical investigation by a medical expert (both Panel Physicians [PPs] and TB specialists). Because the applicant does not possess the knowledge or authority to claim that the information they provide about their corporeal selves is scientifically ‘true’ or accurate, they must seek out medical experts who, through the deployment of the medical gaze, can speak this ‘truth’ on their behalf by scientifically validating their claims. This not only highlights the importance of medical experts in the construction of subjectivities of immigration applicants and newcomers undergoing IMS, but also identifies the medical practice of diagnostic testing (as a means of obtaining medical clearance) as salient to this process.

The medicalization of immigration, and specifically the process of diagnosis, not only produces specific applicants and newcomers, but within the discursive field of medicine it also produces
patients. According to Lupton (1995), “the discourses and meanings surrounding the experience of taking a diagnostic test may be very different for [individuals] compared with ‘official’ interpretations of the process” (p. 99), as has been documented elsewhere (i.e. Chinouya & Adeyanju, 2017; Lupton et al., 1995; Mohammed, 2014). Similarly, in the present study, I observed that while diagnostic testing for TB held meanings for participants in terms of how they viewed their bodies and their health, this was secondary to the meaning that their diagnosis had on them as CIC applicants and new Canadian immigrants. For participants, the diagnosis was primarily political as medical inadmissibility carried real material and social consequences that affected the course of their entire lives.

In biomedicine, however, a diagnosis communicates a different set of norms and expectations of conduct in line with the individual’s social location as a patient. In medicine, “diagnosis…controls, compelling the patient to become obedient to a new set of normative obligations including incapacity and therapeutic compliance” (Jutel, 2009a, p. 61). Therefore the responsibilities and expectations of a ‘good’ patient extend beyond those of the ‘successful applicant / desirable immigrant’. For an individual to be considered a ‘good’ patient within the realm of biomedicine, it is not sufficient to simply ensure that one is not infecting others by treating active TB (which is the primary responsibility of a ‘desirable’ immigrant); rather, it is expected that the individual take responsibility and interest in their overall health by educating themselves about their condition in scientific biomedical terms, investing their efforts and time by adopting new ‘healthier’ behaviours and abandoning ‘unhealthy’ ones, and following the advice of medical and public health experts by taking up practices to manage and minimize their ‘risk’, disciplining not only their bodies but also their desires in light of this new found knowledge about their corporeal selves (Petersen & Lupton, 1996; Pryce, 2000; Rose, 2007). The refusal to conform to these norms and expectations are characteristics of a ‘bad’ patient.

2.3.3 Contesting & Constructing Subjectivities: The ‘Good’ Patient vs. The ‘Desirable’ Immigrant

According to Jutel (2009b), “diagnosis is an important site of contest and compromise, because it is a relational process with different parties confronting illness with different explanations, understandings, values and beliefs” (p. 279). In the context of immigration health screening, diagnosis becomes a site where subjectivities are constructed, reproduced, and negotiated. Subjectivities affect and inform the conduct of individual actors as each “individual has a
personal, emotional investment in presenting her- or himself in a certain manner, as a certain ‘type of person’ engaged in ‘rational’ and ‘civilized’ behaviour consonant with her or his social or embodied position at the time” (Lupton, 1997, p. 105). In the context of immigration health screening, for many participants the meaning and implications of a TB diagnosis was at odds with the biomedical interpretation. According to contemporary logics of biomedicine and public health, a diagnosis of a condition considered to present a ‘risk’ to the health of the patient is interpreted as an imperative for the individual “to do something” to take responsibility for their health and act on medical advice, change behaviours, conduct, and “impels action” (Lupton, 1995, p. 80, emphasis in original). But “doing something” has different meanings for the patient subject versus the immigrant subject. In the context of immigration health screening and surveillance, however, the ‘wrong’ kind of diagnosis is restrictive as it prevents individuals from achieving their goals of becoming a successful applicant, whereas the ‘right’ kind of diagnosis is enabling, allowing applicants to become ‘desirable’ or ‘acceptable’ (and successful) applicants and immigrants.

The findings of the study demonstrate that from the very beginning of the medical encounter, participants engaged with TB clinicians more as ‘desirable’ immigrants rather than ‘good’ patients. Individuals who typically seek out diagnostic screening and surveillance as a preventive initiative for conditions considered to put people’s health ‘at risk’ (such as genetic testing for breast cancer; cervical cancer, HIV, etc.) do so voluntarily; because they participate in diagnostic screening willingly and proactively in the quest for biological self-knowledge, these individuals engage with experts and take part in the diagnostic testing process as “active participants in health” (Howson, 1998; Lupton et al., 1995; Polzer, 2006). Unlike these “active participants in health”, because the TB medical exam was a compulsory part of the immigration application process rather than a voluntary pursuit, participants in this study complied and actively participated as ‘good’ patients during the medical screening and surveillance process only insofar as it enabled them to obtain medical clearance and become the ‘desirable’ immigrant qua successful applicant. Those participants with no prior knowledge about having an underlying health condition (such as LTBI or other pulmonary diseases that would produce abnormal radiographs) complied as ‘good’ docile patients by submitting to the clinical gaze and various medical technologies and procedures for diagnosis as a means of obtaining (assumed) confirmation that their bodies are ‘healthy’. Compliance was also observed as participants
sacrificed time and money to (at times, frequently) attend clinic appointments to complete immigration medical screening not only near their homes, but also in other cities or provinces (which in some cases required extended travel). In my analysis, this form of self-subjugation and self-discipline was consistent with the expected conduct of both ‘good’ patients and ‘desirable’ immigrants.

Participants also engaged as ‘good’ patients by presenting and actively producing information about themselves (i.e. previous chest x-rays and other images, old medical files, pictures of their skin test showing the size of induration, etc.) to medical experts in an effort to facilitate and expedite the process of obtaining a medical diagnosis. Although unsuccessful, some immigration TB patients used this kind of active participation strategically with the aim of convincing the TB specialist that they are not ‘contaminated’ or ‘contaminating’ and, ultimately, manipulate diagnosis in their favour. These attempts at presenting, negotiating, and actively co-constructing oneself as a certain kind of medical ‘case’ by study participants implies that some TB IMS patients may negotiate these medical encounters not as typical patients, but more so as ‘consumers’ in search of the ‘right’ kind of diagnosis – the diagnosis perceivably required to become a ‘desirable’ immigrant.

It is therefore not surprising that participants no longer engaged as ‘good’ patients when the expectations imbued within that social role ceased to align, or altogether conflicted with participants’ perceived understanding of appropriate modes of conduct of the ‘desirable’ immigrant. For instance, diagnosis of LTBI in the context of immigration does not require any action from the ‘acceptable’ applicant, whereas a ‘good’ patient is expected to comply with medical advice and manage the risks this condition presents to their own (and others’) health by prophylactically treating the infection. Fears that accepting preventative treatment would alert immigration authorities that the applicant or newcomer is ‘contaminated’ and therefore no longer ‘desirable’ or ‘acceptable’ as an immigrant subject precipitated in participants’ transgression to TB clinicians’ efforts of inciting participants to be ‘good’ active patients by starting prophylaxis. In this way, an LTBI diagnosis becomes a “site of contest and compromise” in the context of immigration health screening and surveillance, inescapably locating applicants and newcomers in a web of power where they experience having to choose between being either a ‘good’ patient or a ‘desirable’ immigrant. This study suggest that in the context of the immigration medical encounter, when faced with a choice between having to engage as a ‘good’ patient at the expense
of being constructed as an ‘undesirable’ immigrant, or conducting oneself in accordance with the ‘desirable’ immigrant subject position at the expense of being perceived by health care providers as a ‘bad’ patient, immigration TB patients are more likely to choose the latter. Similarly, others have documented that some immigrants and refugees manipulate or resist the regulatory effects of power during medical encounters, specifically in the context of LTBI diagnosis (McEwen & Boyle, 2007) or immigration health screening (Ong, 1995), while other, such as Horton and Baker (2009), noted that, as I argue, some immigrants cannot fully “comply with [expected] standards of healthiness” (p. 793) after arrival in host countries due to social and structural constraints on their conduct as a result of being an immigrant subject (Forero-Quintana & Grineski, 2012; Horner, 2016).

On final note, consistent with both theoretical (Lupton, 1995) and empirical (Horton & Baker, 2009) work, the findings of this study suggest that immigration TB patients who do not take up the social role of the responsible, compliant, and active TB patient may be subject to subtle forms of judgment from TB clinicians. In effect, this only compounds the stress and social difficulties that newcomers already face (in their close personal relationships and during encounters with state authorities) due to TB-related stigma as a result of being constructed as ‘risky’ or ‘dangerous’ through the immigration health screening and surveillance process. Therefore, while the priority for migrants to become a ‘desirable’ immigrant subject may be necessary in the context of the immigration and settlement process, it comes at the expense of being a ‘good’ patient. A ‘desirable’ immigrant must first be a successful applicant, but in order to become one, the individual must negotiate with health care providers to ensure they obtain the ‘right’ type of diagnosis; this is not considered a hallmark of a ‘good’ patient, but rather a ‘difficult’ one. These tensions and, at times, incompatibilities between the subjectivities of the immigrant and the patient influence the ways in which participants construct the self in order to become the successful applicant and, ultimately, not just the ‘desirable’ immigrant but the ‘deserving’ one. This may not only carry social consequences for the individual that extend beyond the clinic into daily life, but also by restricting the degree to which the applicant / immigrant can engage in the medical encounter as a patient subject, may lead to negative consequences for newcomers’ health.
The Canadian TB Clinic: Transforming Foreign ‘Others’ into Biocitizens

In the previous section, I have argued that immigration applicants undergoing TB health screening negotiate power during the clinical encounter to contest and take up various subjectivities so that they may be perceived by state officials first as either ‘acceptable’ or ‘desirable’ applicants and immigrants. The emphasis on medical screening and surveillance as part of the immigration process not only discursively defines the boundaries and identity of Canadians as a “biosocial community” (Rose, 2007) in relation to the diseased foreign ‘other’, but also highlights the importance of ‘good health’ (justifying the regulation and surveillance of immigration applicants as foreign sources of contagion) as a state objective. This is not a novel approach. The concern with health and biology has for long been a central issue for contemporary liberal democratic societies: “specific biological presuppositions, explicitly or implicitly, have underlain many citizenship projects, shaped conceptions of what it means to be a citizen, and underpinned distinctions between actual, potential, troublesome and impossible citizens” (Rose & Novas, 2005, p. 440). In this context, the immigration TB screening and surveillance program can be conceptualized as a regulatory mechanism for the government of immigrants and immigration applicants, and can be understood as part of a larger state citizenship project which relies heavily on the authority of medicine and public health for the production of useful citizens.

Prior to the 1970s, there was prevailing notion that the state ought to be responsible for the health of its citizens. Since then, however, it has become not only accepted but expected that all individuals be accountable for their own health by learning about, managing, and protecting themselves from risk (Petersen, 1997, p. 194). TB immigration health screening and surveillance policies are underpinned by both these notions: on the one hand, the Canadian government screens immigration applicants to detect contagious (pulmonary) active TB disease, preventing these individuals from entering the country in the interest of ‘protecting’ Canadians; on the other hand, those who are constructed as being ‘at risk’ for potential reactivation of LTBI, or those with non-transmissible active TB infection are referred for post-landing IMS where they learn about the risk of their condition and are instructed on how to best manage it. This part of the discussion focuses on the latter group. Furthermore, while IMS is operationalized by both public health and medical practice, study participants focused more on the encounters with health care
providers rather than with public health workers, which provides further justification for the TB clinic as the focus of this discussion. Specifically, in this section I discuss the process by which certain newcomers to Canada (e.g. those referred for TB IMS) are transformed into rational, calculating, self-regulating, contemporary ‘biological citizens’ (Rose & Novas, 2005) through the interaction with TB specialists and clinicians.

Immigration health screening and TB medical surveillance requires “the assessment and government of ‘risk,’ and the maintenance and optimization” (Rose, 2007, p. 10) of foreign ‘contaminated’ bodies. By bringing newcomers into contact with medical experts through mandatory health screening, the medicalization of the immigration process provides a link between the state and population, subtly implicating the institution of medicine “in the exercise of social control” (French & Smith, 2013, p. 386). The medicalization of the immigration process thus extends and locates state power at the site of the TB clinic. By framing health as a political objective, the clinical encounter becomes essential for the exercise of political power where health providers, as sources of expert knowledge, play a crucial role in the citizenship project; as “administrat[ors] of populations and the regulat[ors] of personal identity” (Petersen, 1997, p. 192), TB clinicians participate in the production of healthy, and thus useful, citizens.

3.1 TB Care as Public Health Medicine & the Making of Biocitizens

TB care, as public health medicine, provides a link between the individual and the collective: in line with the ethics of medical care, TB treatment is provided to improve, restore, or maximize the health of the individual; it is also simultaneously done in the interest of protecting the public from being exposed to an infectious pathogen. As such, the TB clinic encounter is a site where both poles of biopower – anatomo-politics and biopolitics – operate to shape the population via the individual. By providing a link between the individual and the collective, TB care becomes relevant for citizenship. (I use the term ‘citizenship’ here as per Petersen and Lupton [1996, p. 62], who define it based on an individual’s “physical presence as ‘body’ within the boundaries of a country” and their belonging to the collective body politic. The other form of citizenship that describes an individual’s immigration status – i.e. the one which distinguishes a temporary or permanent resident from someone who has legal, national Canadian citizenship – I will refer to as ‘political citizenship’).
As new immigrants are granted access to live in Canada, they must become specific types of citizens required in contemporary Western democratic societies – the same types of citizens that are represented in the ‘new public health’ – active biological citizens. This refers to those who take “on personal responsibility for one’s health by accepting and adopting the imperatives issuing forth from the state and other health-related agencies concerning the maintenance and protection of good health” (Petersen & Lupton, 1996, p. 65). A good biological citizen is one who readily engages and participates in civil society by pursuing, achieving, and preserving good health. According to the new public health, health is framed as both a personal responsibility of the individual and a collective duty of all citizens.

The medicalization of the immigration process sets ‘good health’ as a common goal of the state, public health, and medicine. By mandating health screening and surveillance as a compulsory step to ‘citizenship’, the state aligns this goal with that of the immigrant citizen by incentivizing them to take up the call to the imperative of health: Those individuals who comply with public health and state directives around surveillance and self-care with respect to TB have the opportunity to prove that they are ‘good citizens’ by engaging in social and health practices perceived to reflect their willingness to pursue good health with the hope (in spite of fears and doubts) that they will be rewarded with the rights and benefits that come with political citizenship (secure immigration status). It is through TB care received in the context of immigration health screening and surveillance that new immigrants learn to become biological citizens. As immigration applicants undergo health screening, they learn about their illness (TB infection) and the risks that this poses to their health. During the medical encounter at the TB clinic, TB health providers educate the patients about TB, explaining and presenting various options for the course of action. By jointly deciding on the ‘plan of care’, the TB clinician involves the patient in the decision-making process, thus ‘responsibilizing’ the IMS TB patient to take up technologies of the self in line with the expectations of a ‘good’ biocitizen.

### 3.2 TB Medical Experts as ‘Architects of Choice’

Having established TB surveillance and control as a state objective and the TB clinic as a site where foreign ‘others’ are disciplined and transformed into biocitizens (whom, in line with the aims of the new public health, are required to meet this state objective), I turn to a discussion that
examines the role of TB specialists in this process. This first requires a brief return to Foucault’s concept of power.

The mandate for immigrants to undergo health screening and report for medical surveillance is an exercise of sovereign power. This type of power “operates primarily in a repressive manner through the imposition of law upon the bodies of subjects” (Tierney, 2004, p. 282). In contrast, “power[,] as it operates in the medical encounter[,] is a disciplinary power that provides guidelines about how patients should understand, regulate and experience their bodies” (Lupton, 1997, p. 99). Clinicians exercise a specific form of disciplinary power: pastoral power. In contrast to sovereign power, pastoral power is “salvation-oriented” (Foucault, 1982, p. 214) and productive, exercised by doctors through concern and responsibility for those under their care (Lilja & Vinthagen, 2014, p. 119). The only way that pastoral power can be exercised is by “knowing the inside of people’s minds,” by “exploring their souls” through revelations of “their innermost secrets” (Foucault, 1982, p. 214). In the clinical encounter, the doctor learns about the patient through the clinical form of ‘confession’, by asking the patient to recount their present and past medical history, as well as their “social history” (Tierney, 2004). Once the relevant and intimate details about the patient’s lives are known, the doctor is able to direct the patient’s “conscience” in a way that would ensure their “salvation” – which, in this case, refers to their health and wellbeing (Foucault, 1982, p. 214).

This conceptualization of power raises questions about the role of TB clinicians in relation to their patients. Since power is not something that can be possessed by any one individual or group, despite being implicated in the production of ‘biocitizens’, TB health care providers cannot be perceived as “figures of domination”; instead, as Foucault suggests, they are “an important link in a set of power relations […] through whom [state] power passe[s]” (Foucault, 2010d, p. 247). In other words, health care providers can be perceived as mediators between ‘authorities’ and ‘individuals’ (Miller & Rose, 1990, p. 19). It is important to make clear, however, that although clinicians are vehicles through which power is transmitted, their participation is not neutral; they are simultaneously agents who exercise power. Thus, the ways in which TB clinicians exercise power in the context of the medical encounter in turn shapes the conduct of their patients.
Consistent with the conceptualization of pastoral power, it can be argued that in their professional capacity, TB specialists take on the role of ‘architects of choice’ by, after learning of a patient’s LTBI diagnosis, presenting patients with options for the plan of care or other forms of managing the risk of a latent TB infection. Thaler and Sunstein (2008) define a choice architect as someone who “has the responsibility for organizing the context in which people make decisions” (p. 3). However, they contend that “there is no such thing as a ‘neutral’ design” and that “seemingly arbitrary decisions” about how choices are presented “will have subtle [yet significant] influences” on what the subject will choose (Thaler & Sunstein, 2008, p. 3). Particularly in relation to clinical practice, doctors as ‘pastors’ not only present various therapeutic options to patients, but also do so with the intention of “nudging” – subtly influencing individuals to make, what they believe to be, the ‘correct’ choice (Thaler & Sunstein, 2008, p. 5). ‘Nudging’ and choice architecture is only possible, however, so long as the subjects have ability to exercise their agency and freely choose any option presented to them. As such, to be effective, the TB clinician as a choice architect requires the patient subject to participate as a rational, calculating, responsible, and free citizen. It is through the exercise of power between the clinician and patient during the TB clinical encounter that the immigrant subject becomes the biocitizen.

3.3 Biopedagogy, Health Education & the ‘Option’ of Prophylaxis

Biocitizenship requires the pursuit of good health. Good health, however, often cannot be achieved without appropriate guidance and direction. Biological citizens are obliged to be informed about their illnesses, their present and future risks, and are required to act responsibly by taking appropriate measures to minimize illness and maximize health; this task requires engagement with experts and reliance on expert (biomedical and public health) knowledge not only to learn about oneself, but also to obtain instruction in the care of one’s own body (Rose, 2007, p.147). As Rose (2007) points out, “biological education of the citizen remains a national priority, although it is now supplemented by a host of other forces seeking to shape the reflexive gaze through which the citizen views his or her past, present, and future biological corporality” (p. 139). Biopedagogies thus become essential to the making of biocitizens by informing behaviours and practices associated with the body (Harwood, 2009; Wright, 2009). The term ‘biopedagogy’ refers to the conceptualization of health education as a form of biopower
(Gastaldo, 1997) which is directed at individuals, offering them “a number of ways to understand themselves, change themselves and take action to change others and their environments” (Wright, 2009, p. 2). In the context of IMS, this concept offers a useful way to understand the function of TB health education in governing immigrants. Lastly, because health education in this study primarily took form of a relational practice occurring at a micro-political level, it involved and enabled various forms of control and resistance (Gastaldo, 1997).

In the context of immigration medical screening and TB surveillance, both the TB clinician and the immigration TB patient actively participated in the transformation of the foreign ‘other’ into a biocitizen. Through bilateral engagement in the clinical interview, the health care provider incited the patient to ‘confession’ in order to establish the reason for the referral to the clinic, construct the patient as a medical ‘case’, construct the patient’s TB risk profile, and establish a diagnosis. Through the deployment of the clinical gaze, this process allowed for the creation of knowledge about the patient as a medical subject with implications for both the clinician and the patient. For the clinician as ‘pastor’, this enabled them to get to know the “conscience” and “soul” of the patient so that when they presented the patient with therapeutic options, they could ‘nudge’ them effectively towards the ‘correct’ choice (prophylaxis) by acting upon the patient’s desires (which, in medical practice, is known as the “patient-centred approach” [Mayes, 2009]).

For the TB patient, the information gathered through ‘confession’ was interpreted by the clinician through the clinical gaze and presented to the patient in the form of health education about the self, as well as TB in general.

Health education was an integral component of the IMS TB clinical encounter and served an important function in the production of the biocitizen. Through health education, the TB patient as biocitizen fulfils their obligation to learn about their body, their disease, and their health. Because TB clinicians and immigration patients were governed by competing logics, clinicians faced an added challenge of having to persuade participants to take up the medical gaze and regard their asymptomatic condition (LTBI) as a legitimate threat to their health. The knowledge about their health condition was thus framed within discourses of ‘risk’, which simultaneously allowed for the presentation of various biomedical and therapeutic options and strategies available to the patient to minimize this risk. These options, however, were also delivered and presented as a form of health education because of the need to translate biomedical knowledge (including therapeutic intervention) in a way that was meaningful to the patient. Individuals with
(suspected or confirmed) LTBI were presented with two options: either to undergo preventative treatment to eliminate the infection, or not to treat it. Consistent with contemporary health promotion strategies under the ‘new’ public health, in the context of immigration medical screening and surveillance, prophylaxis was framed by clinicians as an option to consider solely ‘in the interest of one’s own health’.

Undergoing the medical assessment was a compulsory part of the immigration application and required subjugation of the participant. In contrast, however, after receiving a diagnosis (and fulfilling the immigration requirements for TB medical surveillance), any decisions made about the patient’s plan of care were optional and exorted the patient to actively engage in the negotiation of power. While on the one hand clinicians encouraged free choice, the findings suggest that in accordance with biomedical logic, TB health providers believed that for many recent immigrants with LTBI preventative treatment was the ‘correct’ choice. In effect, some clinicians were observed to subtly ‘nudge’ patients towards this ‘choice’ in several ways: by dismissing participants’ rejection of prophylaxis until they were fully informed about all relevant biomedical facts and risks, and repeatedly bringing up preventative treatment as an ‘option’ during each clinic visit. While those patients who took up the call to begin prophylaxis were praised for making a ‘smart’ decision (and were thus constructed as, and rewarded for being, responsible and rational individuals), some who decided not to pursue this option (e.g. Sunny) were subject to subtle forms of moral judgment by clinicians. Consistent with the “patient-centred” approach that underpins medical practice in Canada, the findings suggest that while TB specialists preferred that patients complete a course of prophylaxis, they did not explicitly state their opinion about what therapeutic decision they believed the patient should make; instead, through the deliberate presentation of possible options and reliance on the logic of science through health education and health promotion, clinicians strategically ‘nudged’ the patients not only to convince them that prophylaxis is the ‘correct’ choice, but also to do it in such a way that makes the patient believe they came to that conclusion of their own volition.

Health education at the TB clinic did not stop after the IMS TB patient rejected preventative treatment. If the patient decided against prophylaxis, depending on the TB specialist’s interpretation of the individual’s risk of progressing to active TB disease, the patient was either instructed to return for another chest x-ray at a future date for further follow-up and monitoring (if believed to be at higher risk), or was taught about, and instructed to look out for, signs and
symptoms of active TB disease (if believed to be at lower risk). In both scenarios, the clinical
gaze continued to extend over the newcomer either directly through medical surveillance at the
TB clinic, or indirectly as the clinical gaze became internalized and turned on the self, exhorting
the patient to engage in ongoing daily self-examination for signs of contagion and disease at any
point during their settlement period and beyond. Given the study findings, it becomes clear that
even in light of patients’ refusal of therapeutic intervention, health professionals continued to
seek to “transform the awareness of individuals in such a way that they become more self-
regulating and productive both in serving their own interests and those of society at large”

3.4 Resistance as Act of Biocitizenship: Failure or Success?

The articulation of biomedicine and public health logics in the context of IMS TB care gives rise
to tensions described by Lupton (1995) between the public health idea of the TB client as an
active, rational, and responsible citizen, and the pastoral idea of the docile TB patient as the
subject in need of persuasion and encouragement to “‘do the right thing’” (p. 61). While some
participants decided to begin prophylaxis, others did not. It is interesting to discuss how the act
of ‘resistance’ (e.g. the rejection of expert advice, particularly prophylaxis) in the context of the
immigration TB clinical encounter can be interpreted in the context of the citizenship project that
aims to construct newcomers as useful biocitizens. I would contend that such resistance can be
seen as both a ‘failure’ and a ‘success’, depending on the perspective.

The study findings suggest that in the context of TB medical care as public health medicine, TB
patients were implicitly expected by clinicians to be both docile patients and active biocitizens.
On the one hand, they are free to make whatever choice they believe to be best for them (though
the implicit expectation is that as active citizens, they will regard their health in biomedical terms
and, consistent with the expectations of a rational citizen, they will come to view preventative
treatment as the ‘right’ option). On the other hand, however, TB patients are simultaneously
constructed as in need of education and guidance, and should heed the advice (or ‘nudge’) of the
clinician in making the ‘right’ choice. In effect, a patient’s rejection of prophylaxis may be
perceived as a failure on the part of the citizen to fulfill their duty and obligation because it
constructs the patient as irresponsible, deliberately “opting for unhealthy behaviours after some
health education activity” (Gastaldo, 1997, p. 117). Secondly, according to the logic of the ‘new’
public health, it is believed that while all active citizens have the potential to conduct themselves in ways that will help them achieve good health, it is the responsibility of the health expert to assist citizens in realizing this potential (Lupton, 1995, p. 61). Therefore rejecting prophylaxis may be perceived as the TB clinician’s failure (as a health provider) to effectively incite the patient to take up the imperative of health (Gastaldo, 1997, p. 117) and make therapeutic decisions according to biomedical logic.

An alternative perspective, one that considers the intersecting competing logics of immigration, public health, and medicine, would suggest that resistance during the immigration TB medical encounter could actually be indicative of the successful transformation of the foreign ‘other’ into a biocitizen. It has been argued by many that tensions in the doctor-patient relationship (which structures the micropolitical context of the clinical encounter) arises from competing forms of knowledge shaping the attitudes and conduct of patients and health care providers (i.e. Mayes, 2009; Petersen & Lupton, 1996; Pryce, 2000). This difference, and thus tension, can be amplified in a cross-cultural context (Anderton et al., 1989; Holmes, 2012; Manassis, 1986; Ong, 1995). Petersen and Lupton (1996) argue that a “commonly identified source of difficulty … is the ‘misunderstandings’ and ‘conflicts’ that arise between experts and lay people resulting from differences in the way they approach decision making. Whereas health professionals base their judgments on scientific ‘objective’ knowledge, so one argument goes, lay people employ common sense, ‘subjective’ evaluations” (p. 153). These tensions and misunderstandings can lead to various forms of patient resistance during the clinical encounter, particularly if the medical advice is interpreted by patients as conflicting with their personal objectives (McEwen & Boyle, 2007; Michaels et al., 2008; Palmieri & Stern, 2009; Pryce, 2000; Wheatley, 2005).

Based on the study results, I suggest that the tensions observed between immigration TB patients and TB clinicians in the context of the immigration TB medical encounter arise from the competing logics that govern the conduct of both groups of social actors. TB specialists and clinicians were informed by biomedical logics; in contrast, while study participants were observed to take up biomedical forms of knowledge to regard their health condition, their decisions, motivations behind their participation, and level of engagement and compliance with medical advice were primarily interpreted in the context of the immigration and settlement process. Although most participants may have refused prophylaxis, the data suggest that as a result of the TB medical encounter, participants had come to view TB as a biomedical condition:
during clinic appointments, participants engaged clinicians and framed LTBI infection and prophylaxis in terms of ‘risk’ to determine whether prophylaxis really *would* optimize their health; participants also considered the risks of reactivation of latent infection (e.g. Jane rejected prophylactic treatment as she perceived the risk of side effects of the medication to be greater than her individual risk of developing active TB infection). Furthermore, even though some declined treatment, after the clinical encounter participants expressed the desire to, at some point in the near future, “want to cure [their] disease” (Sunny). Ultimately, while participants considered their therapeutic options in biomedical terms, their decision also, and primarily, took into account CIC requirements and the social and material conditions of the immigration and settlement process.

The ideal biological citizen is a rational, “responsible subject[t] whose moral quality is based on the fact that they rationally assess the costs and benefits of a certain act as opposed to other alternative acts” (Lemke, 2000, p. 5). While some participants in this study may have rejected biomedical advice, resisting disciplinary power (which is in line with the expectations of active citizens), they took up biopower by exercising their agency and free will and coming to their therapeutic decisions through a rational process. In this way, immigration TB patients’ rejection of prophylaxis should not necessarily be viewed as a failure of experts to incite immigrants to participate in these specific strategies of self-care, but can rather be viewed, as pointed out by Minson (1993, as cited in Petersen & Lupton, 1996, p. 162), as “successful resistance to imposed relations aimed at their ‘liberation’, as well as individuals’ recognition of the personal and interpersonal demands of ‘participation’ and of the limits of negotiation”. The study results indicate that both immigration and medical logics inform IMS TB patients’ therapeutic decisions around preventative treatment, which implies that participants’ perceptions of well-being are not only limited to their biology, but also include social and economic aspect of life. While TB clinicians may perceive rejection of prophylaxis as a ‘failure’, the results of this study suggest that regardless of whether immigration TB patients accepted or rejected prophylaxis, either choice “could be seen as engaging in practices of the self that they consider are vital to their own well-being” (Lupton, 1997, p. 105). In this way, similar to what others have suggested (Horton and Barker, 2009; Molina, 2006; Ong, 1995, 1996), it could be argued that clinicians, as choice architects, successfully mediated in transforming foreign ‘others’ into rational biological citizens.
through health education, by encouraging them take up new knowledges about their body, and by inciting newcomers to take up new practices of self-care and self-surveillance.

4 Critical Perspectives on TB Immigration Health Screening & Surveillance

In this third and final section, I pick up on different aspects of my arguments from the previous two sections to problematize the Canadian TB immigration health screening and surveillance process. The TB screening and surveillance program as part of immigration is a disciplinary regime strategically deployed to control and normalize immigrant bodies. The medicalization of the immigration process implicates the institution of medicine “in the exercise of social control” (French & Smith, 2013, p. 386), enmeshing newcomers, public health workers, and TB health care providers located within this process in a complex web of power. This brings newcomers into contact with medical experts and provides an opportunity for the extension of medical authority through both disciplinary power and biopower into the daily lives of immigrants during the process of immigration and settlement in Canada.

In this last section, I discuss the effects of medicalization of immigration on newcomers and clinical practice in the context of TB medicine. First, I argue that the discursive construction of TB among immigrants primarily as a biosecurity threat exhorts applicants to take personal responsibility to assure the Canadian government that they are not ‘contaminating’. This discursive framing overlaps with the notions of individual responsibility in contemporary public health and biomedical discourses around self-discipline and care of the body, which has profound negative consequences for immigrants both before and after immigration. Second, I argue that while some overlap exists, in other ways the medicalization of immigration conflicts with the aims and objectives of public health approaches to TB prevention and control and, as such, complicates the clinical management of TB among this population.

Biomedical and public health discourses draw on biomedical explanatory models of TB as a problem of the individual body, promoting clinical management of TB and privileging curative approaches to eliminating the infection (even as a preventative strategy). A public health approach to TB prevention and control centres on the calculation of risk, identification and monitoring of ‘at risk’ groups, and further encourages taking up of technologies of the self to manage risk. Within discourses of immigration, the discursive framing of TB as an ‘imported disease’ and an external threat, as well as the identification of “recent immigration” as a risk category for the reactivation of LTBI, provides the impetus to not only closely monitor new immigrants with suspected TB infection in the name of prevention, but also justifies the need for preventative treatment of newcomers diagnosed with LTBI. Thus the overlap of medical, public health, and immigration discourses reinforce notions of TB control as a personal individual responsibility, exhorting newcomers as both CIC applicants and TB patients to actively engage in screening, surveillance, and risk management practices.

Biomedical logic and public health notions of disease prevention assume that screening and surveillance is beneficial to individuals and the population. Lupton (1995) points out, however, that “a diagnosis based on a medical test is not purely objective, technical event, but relies upon the social context of both doctor and patient, and may or may not be beneficial for the patient” (p. 93). On the one hand, early disease detection is framed as advantageous, providing individuals with the opportunity to take control of their bodies and avert or stall the onset of illness through preemptive therapies (Gillespie, 2015; Lupton, 1995; Seedat et al., 2014; Timmermans & Buchbinder, 2010). While discourses of ‘risk’ are an “attempt to tame uncertainty” (Lupton, 1995, p. 79), paradoxically, as Wilkinson (2001) points out (which is particularly relevant in the context of immigration TB health screening and surveillance), knowledge of risk can also have the opposite effect by “accentuat[ing] the (potentially hazardous) uncertainty” (p. 90). In contrast to discourses promoting the benefits of screening and surveillance for disease prevention, many have written about the profound negative social effects of health screening on the individual, namely increased diagnostic uncertainty and the subsequent experience of liminality between health and illness (Gillespie, 2012, 2015; Hallowell
et al., 2004; Lupton, 2015; Timmermans & Buchbinder, 2010), making people vulnerable to anxiety and other forms of social suffering (Wilkinson, 2001, 2006). As it relates to immigration health screening specifically, others (Horner, 2016; Horton & Baker, 2009) have also documented that categorizing migrants as ‘risky’ in the context of immigration locates them in a liminal space as immigrant subjects after arrival in the host country.

In this study, liminality was observed both in relation to participants’ understanding of their own health as well as their immigration status. When participants received their initial notification to undergo additional TB testing, they encountered a prolonged period of suspense (sometimes lasting several months) waiting for confirmation of their diagnosis. The fear and anxiety associated with waiting for diagnostic results to confirm TB infection have been reported by others (Gerrish et al., 2013). After receiving medical clearance and CIC application approval, the referral for post-arrival IMS once again constructed participants as ‘risky’, raising doubts for them about the initial TB diagnosis. Having to undergo the screening and surveillance process once again, newcomers were thrust into a liminal space of uncertainty between healthy and ill for the second time. This diagnostic uncertainty raised fears and anxiety for participants altering not only their health identities (Gillespie, 2012; Wilkinson 2001, 2006), but also their identities as new immigrants by raising doubts about the status of their CIC application. Those who already obtained medical clearance and approval of their applications were technically considered ‘desirable’ immigrants. However, their (re)constitution as ‘risky’ through the referral for follow-up medical surveillance placed a “condition of landing” on their application, thrusts their immigration status into uncertainty and, politically, a space of liminality (Horner, 2016).

Individuals undergoing health screening are vulnerable to physical, emotional, and social suffering (Gillespie, 2012; Hallowell et al., 2004; Wilkinson, 2001, 2006), as was observed among participants in this study. The designation as ‘risky’ and potentially ‘dangerous’ through the process of mandatory TB testing contributed to the psychosocial and emotional distress that participants were already experiencing as ‘biologically liminal subjects’ from diagnostic uncertainty due to the stigma surrounding TB. First, the charge of potentially being infected with TB, as implied through mandatory TB screening and surveillance, is in and of itself socially stigmatizing as it is interpreted as a potential threat to self and others. Because participants were unfamiliar with and unclear about the objective of immigration health screening, the screening and surveillance process itself; or the implications of diagnostic outcomes on their application,
the meaning of the referral for further medical investigation itself in the context of immigration was misinterpreted by some participants and their families not as suspicion of TB, but rather as confirmation of TB. While most participants did not actually have active TB and did not pose a ‘danger’ to others, some were perceived as ‘contaminated’ and ‘contaminating’, and, in effect, were stigmatized by those around them. Although some participants’ personal relationships suffered because they were stigmatized by others, there were also those participants who internalized this stigma themselves and intentionally withdrew from society for fear of potentially putting others at risk. The complete lack of official information available to applicants about TB as a biomedical disease, as well as the implications of diagnosis for their immigration status, exacerbated uncertainties and amplified anxieties as participants moved along the Migratory Pathway.

Physical suffering was caused by having to repeatedly undergo compulsory medical testing as liminal immigrant subjects. Because in the context of immigration health screening and medical tests are framed the applicant’s responsibility, participants were required to invest time, effort, and money to complete even one round of testing (in order to become a successful applicant), let alone two (to prove they are ‘desirable’ and ‘deserving’ immigrant). While it may be argued that IMS medical assessments are covered under health insurance, the study findings suggest that this only applies to a small percentage of applicants and new immigrants. Some may be lucky and complete IMS medical assessments free of charge if the medical assessment is conducted in a community health clinic, a specialized TB clinic where individuals may be eligible for TB-UP, or, if the individual is a permanent resident, they wait until they receive provincial health insurance (OHIP). In other cases, however, temporary residents’ health insurance plan may not cover immigration-related expenses, or insurance companies may refuse coverage for TB screening because they consider TB a pre-existing condition (as it was discovered during the IME prior to coming to Canada). While others still may have adequate health coverage (e.g. IFHP for refugees), the administrative confusion about billing immigration-related medical screening and services by health care providers who are not familiar with the IMS process (e.g. primary care physicians) may result in unwarranted rejection of newcomers’ health insurance, resulting in unnecessary out-of-pocket payment for IMS TB testing. Lastly, even in situations where newcomers have access to adequate health coverage, such as permanent residents, the fear of punitive action by immigration authorities compounded by the effect of stigma may prompt
individuals to unnecessarily seek out physicians outside of requirements of IMS to obtain medical clearance during the 3-month waiting period before they are eligible for OHIP.

4.2 Effects of Immigration TB Health Screening on the Clinician-Patient Relationship

Because the practice of immigration health screening and TB surveillance is underpinned by concerns around biosecuritization of borders (Horner et al., 2013) as a state rationale, I contend that the TB prevention and control program directed at immigrants is more about the managerial control of ‘contaminated’ foreign bodies rather than the provision of medical care to some of the most vulnerable social groups in Canada. Under current TB prevention and control program, TB health care providers are tasked with balancing their professional role as healthcare providers to the individual patient with the added role of safeguarding the health of the nation. In addition to providing medical care to the individual, my analysis suggests that in the context of immigration, TB health providers (unwittingly) perform three additional roles: they act as mediators in the biopolitical process of transforming foreign ‘contaminated others’ into biocitizens; they are integral to the constitution of prohibited applicants and govern the entry of foreign others; and, as administrators for CIC, TB clinicians are exhorted to assist in the policing and management of ‘contaminated’ immigrants.

Through access to scientific knowledge about the human body, TB health care providers act as gatekeepers for immigrants during the immigration and settlement process. “Diagnoses are the classification tools of medicine” (Jutel, 2009b, p. 278). As such, reliance on medical experts to provide and confirm TB diagnosis for the purpose of immigration application highlights the critical role of medical experts in the ordering and segregating applicants. Within the domain of medicine and in relation to medical care, diagnoses are productive: they are useful for “identifying treatment options, predicting outcomes, and providing explanatory frameworks” (Jutel, 2009b, p. 278). Even through their administrative functions, within the medical domain, diagnoses are productive as they “enable access to services and status, from insurance reimbursement to restricted-access medication, sick leave and support group membership and so on” (Jutel, 2009b, p. 278).

In the context of immigration, however, and particularly as it pertains to a stigmatized disease such as TB, a diagnosis takes on a new meaning and has very different effects for the recipients
of this new knowledge. While TB screening in the context of immigration may uncover a hidden pathology and provide an opportunity for much needed access to medical care to newcomers, from an administrative standpoint, an active TB diagnosis made during the IME is repressive as it disqualifies the applicant (albeit temporarily) from entering Canada, halting the CIC application process. From the perspective of medical practice, this presents a problem as it changes the nature of the doctor-patient relationship. Implicating doctors as administrators of the state undermines and conflicts with medical ethic of care by shifting the focus of the medical encounter from providing medical care to sorting ‘desirable’ immigrants and applicants from the ‘undesirable’ ones. Moreover, the process of selection of immigration applicants is underpinned by moral indifference (i.e. the lack of compassion towards individual applicants as people in bureaucratic processes which facilitate and uphold the objectives of border control) (Gill, 2016), which stands in direct conflict with the objectives and ethics of medical practitioners. Furthermore, the cooption of TB specialists into the immigration process affects CIC applicants’ and immigrants’ perception of, and relation to, TB clinicians. Because the referral to the TB clinic is obligatory in the context of immigration, most immigration TB patients are not interested in engaging with clinicians in pursuit of their health. While the encounter may provide useful and important information to applicants and newcomers about underlying pathologies and health conditions and present an opportunity for therapeutic treatment, the concern with biosecurity undermines and overshadows the productive potential of this encounter. Instead, consistent with others’ conclusions (Ong, 1995), the findings of this study suggest that rather than perceiving TB clinicians as health authorities, newcomers and CIC applicants regards TB clinicians primarily as administrators and state officials who happen to be health experts. It can be argued that the medicalization of immigration shapes newcomers’ perception of health care providers in significant and potentially negative ways. Research shows that negative health care experiences and certain immigration policies that expand bureaucratic functions of citizenship into the institution of medicine can have harmful effects on immigrant health by deterring newcomers from seeking health care services in the future and instilling distrust against physicians as health care providers (Pedraza et al., 2017; Suurmond et al., 2011), which compounds already existing barriers for newcomers in accessing health care after arrival in Canada (McKeary & Newbold, 2010). Although in Canada physicians do not have a responsibility to enforce immigration policies, for example, the perception of health care
providers as state authorities is sufficient to cast doubt and skepticism on the role of physicians, undermining the trust required in a traditional doctor-patient relationship.

Lastly, being able to provide applicants and newcomers undergoing immigration TB screening and surveillance with the ‘right’ diagnosis (i.e. one that enables them to be successful applicants and ‘desirable’ immigrants) constructs TB specialists as the applicants’ guarantors for obtaining application approval or securing immigration status. The authority afforded to them as experts of scientific knowledge makes TB specialists strong advocates for newcomers in the context of immigration to support or deny newcomers’ claims to being ‘deserving’ immigrants by confirming their compliance with government-mandated directives. This role is in line with TB specialists’ professional responsibility and ethic of care to not only ensure health of the body, but also to provide care to the individual.

5 Chapter Summary

In this chapter, I interpreted the study findings through the framework of governmentality to put forth three arguments. First, I argued that the intersection of medical, public health, and immigration discourses (which I refer to as the ‘medicalization of immigration’) prioritizes the detection and exclusion of foreign ‘contaminating’ bodies, resulting in the construction of the ‘desirable’ immigrant subject. This subjectivity both supports and conflicts with CIC applicants’ and newcomers’ ability to engage in the TB medical encounter as ‘good’ patients. Second, I argued that the medicalization of immigration implicates health care professionals, specifically TB specialists, in the state citizenship project of transforming foreign ‘others’ into biocitizens. Third, I provided a critical perspective on some of the effects of medicalization of immigration and argued that the organization of the immigration and settlement and immigration health screening and TB surveillance processes thrusts applicants and newcomers into liminality, causing significant anxiety and suffering. Moreover, the medicalization of immigration unwittingly responsibilizes health care providers to participate in the bureaucratic management of TB IME and IMS patients, which can undermine the doctor-patient relationship with potential negative consequences for the health and wellbeing of immigrants.
Chapter 9
Conclusion

1 Summary of Key Ideas

Immigration TB screening and surveillance is a significant part of the Canadian immigration program (PHAC, 2014a). Despite the long-standing practice of screening immigration applicants for TB and their subsequent referral for medical surveillance after arrival in Canada, it is currently unknown what effects this policy and practices have on newcomers, as the immigrant perspective is not typically represented in scientific literature. Moreover, while there is an increased interest in addressing the social “underlying vulnerability of migrants” as part of successful TB control strategies (WHO, 2014a, p. 31), there is surprisingly little published research that examines these vulnerabilities and other social realities of immigrants in the context of TB control, particularly in Canada.

This study examined the experience of new Canadian immigrants and immigration applicants undergoing immigration TB health screening and surveillance, and focused on the social effects of this process on the daily lives and overall health and wellbeing of newcomers. This study employed Foucauldian Discourse Analysis as both a research methodology and analytic approach to understand the effects of the overlap of immigration, public health, and medical discourses on both the macro-level (i.e. organization and procedural structure of immigration and settlement, and immigration medical surveillance [IMS]) and micro-level (i.e. the power relations between applicants/newcomers and experts, particularly health care providers). Drawing on Foucault’s concepts of governmentality, discourses and knowledge/power, the first objective of this study was to understand how the articulation of three discursive fields (immigration, public health, and medicine) produced discourses and discursive practices aimed at immigrants, and how, in turn, this governed the conduct of applicants and new immigrants during the immigration and settlement process, both in Canada and abroad. My second objective was to examine the ways in which immigrants undergoing TB medical screening and surveillance negotiated power throughout the different stages of the immigration and settlement process, particularly at the site of the Canadian TB clinic.
The results of this study revealed that the immigration and settlement process is much more complex than it is described in official immigration policy documents; this process is further complicated by compulsory immigration health screening aimed at detecting TB infection among immigration applicants. I argue that the medicalization of the immigration process (i.e. the structural and procedural effects of the intersection of immigration policy, public health, and medicine) produces different sites for the government and construction of immigrant subjects suspected of TB. The tensions between the competing logics of immigration, public health, and medicine, along with a lack of official instructions and information available to applicants about the process of TB screening and its implications for the status of their application, present not only structural barriers to political ‘citizenship’ (i.e. secure immigration status), but also produces multiple negative social and material effects for newcomers. Moreover, the medicalization of immigration unwittingly implicates TB specialists in the project of regulating, monitoring, and ‘correcting’ ‘infected foreign others’, revealing that TB health providers as well as newcomers are embedded in a complex network of power which shapes the conduct of all social actors involved in this process.

Based on analysis of study data generated through participant interviews, observations of TB clinic appointments, and field notes of observations in the TB clinic, I put forth three main arguments. First, I argue that the discourses that arise from the intersection of competing logics of immigration, public health, and medicine not only shape the micropolitics of power in interpersonal encounters, but also produce competing subjectivities that are negotiated by participants through resistance, compliance and active participation throughout the Migratory Pathways. The medicalization of immigration produces tensions at the micropolitical level of the TB medical encounter as the intersection of these discourses simultaneously produces conflicting identities of ‘desirable’ immigrants and ‘bad’ patients; in order to become a ‘desirable’ immigrant, applicants, as TB IMS patients, must sacrifice being a ‘good’ patient during the TB immigration clinical encounters, which may have negative consequences for their health.

In my second argument, I examine the role that TB health care providers play in the state project of transforming foreign ‘others’ into biocitizens (Rose, 2007). Immigration medical surveillance is a technology that produces knowledge and power about and over immigrants, constructing them as foreign ‘diseased others’ who are discursively excluded from the Canadian ‘biosocial community’ (Rose, 2007). I contend that through biopedagogies, TB clinicians become ‘choice
architects’ ‘nudging’ (Thaler & Sunstein, 2008) newcomers towards taking up biomedical discourses and technologies of the self (such as self-discipline and self-surveillance) to both view themselves in corporeal terms and to discipline and manage themselves in relation to biological ‘risks’ (Lupton, 1995) in light of their TB diagnosis. In this way, by encouraging immigration TB patients to actively take up practices and govern their own conduct in the interest of achieving and optimizing good health, foreigners become ‘responsibilized’ to become biological citizens. While some individuals might reject expert medical advice, I contend that this act is not necessarily indicative of failure of transforming others into biological citizens because resistance can “be seen as engaging in practices of the self that [the individual] consider[s] vital to their own wellbeing” (Lupton, 1997, p. 105).

Third, I argue that the medicalization of immigration entangles all social actors in a web of power and is paradoxically detrimental to the health and wellbeing of newcomers to Canada for two reasons. First, the uncertainty surrounding the process and meaning of a TB diagnosis inserts applicants and newcomers into a liminal space in terms of the ways in which they understand their own health as well as the perceived implications that the ‘risk’ and ‘threat’ of TB has on their immigration status. Similar to what others have reported (Gillespie, 2012; Wilkinson, 2001, 2006), this study reveals that such uncertainty causes significant physical, social, and emotional suffering for applicant and newcomers. Second, the medicalization of immigration unwittingly implicates TB health care providers in the difficult position of state authorities. As the ‘wrong’ kind of diagnosis carries with it the potential burden of conviction, labeling applicants and newcomers as ‘contaminating’ and thus ‘undesirable’, constructing TB specialists as wardens undermines the trust that is essential to a successful doctor-patient relationship. I argue that co-opting the institution of medicine into the policing of borders and the surveillance and management of ‘contaminated’ immigrants corrodes the very pillars on which medical care stands, potentially carrying with it negative effects for the health of newcomers.

2 Contributions to Knowledge

The most significant contribution of this study has been the deepened understanding of how newcomers experience the immigration and settlement process, including TB immigration health screening and medical surveillance processes, and what effects this has for them as future Canadians. This study was unique as it linked individual experience, interpersonal processes, and
structural organization to explain the social dimension of immigration TB screening and surveillance and TB medical care (Mason et al., 2015). In this way, the present study answers the call to represent and prioritize the perspectives of immigrants themselves, bringing attention to the agency and experiences of individuals affected by TB (Abarca Tomas et al., 2013; Forero-Quintana & Grineski, 2012; Lin & Melendez-Torres, 2016; Mason & Degeling, 2016), which brings a much needed sociological dimension to complement current dominant biomedical approaches to addressing the problems of TB prevention and control globally.

Through my analysis, I have also provided a comprehensive explanation of some of the ways in which overlapping immigration policies, public health policies, and guidelines for clinical practice shape the organization and structure of the immigration process (e.g. Migratory Pathways), particularly in Canada. This information is relevant for both immigration and public health policy as well as TB clinicians. While much is known about TB from a public health and biomedical perspective, these discourses and logics dominate scientific literature, often identifying proximal individual factors as sources of problems around TB prevention and control. In contrast, this study not only answered to the call to privilege the voices and perspectives of newcomers in an effort to broaden the understanding of how these policies and practices impact the daily lives of individuals governed by them, but also, by doing so, has contributed to the growing body of social research about TB by helping to identify the more complex social factors that are, in many cases, beyond the control of individual actors.

This study also contributes to the growing body of literature that considers social determinants of health as a conceptual framework to understanding health inequities, and identifies ‘migration’ (or the immigration process) itself as a social determinant of TB among immigrant populations in destination countries. While this study was undertaken in Canada, the results are applicable to other high-income immigrant-receiving nations with similar immigration health screening practices and programs such as Australia, the U.S., and Western European countries.

From a theoretical perspective, this work answers the call for investigating and problematizing the seemingly benign practice of medical surveillance and its effects for individuals and populations. French and Smith (2013) pose a strong argument in support of such critical examinations of the practice of ‘health’ surveillance, stating that
health-related surveillance is not a straight-forwardly unproblematic undertaking. It might serve progressive objectives and the forces of positive social change, empowering individuals and populations to take better care of their health. It may also – in spite of being undertaken in the name of health – be bound up with processes that discriminate, marginalize and ultimately militate against social justice. (p. 383)

Foucault’s work on governmentality, discourses, and knowledge/power has provided a useful framework for such an investigation. This study is a contribution to the growing scholarship supported by Foucauldian concepts to examine TB immigration health screening (Horner, 2016; Horner et al., 2013; McEwen & Boyle, 2007). Through my analysis, I have not only shown the ways in which power relations are shaped through the “internal rationality” (Foucault, 1982, p. 211) of policy discourses, but also at the micro-level by antagonizing strategies of negotiating power. To that point, this study is the second to specifically document and analyze the strategies of resistance used by immigrants in negotiating the TB clinical encounter (see McEwen & Boyle, 2007), and the first to do so in a Canadian context. This is significant for two reasons. First, as Lilja & Vinthagen (2014) contend, an analysis of resistance strategies is a deviation from typical Foucauldian methodologies, which are preoccupied with the Foucauldian concept of ‘power’. And second, according to Foucault (1982) himself, “taking the forms of resistance against different forms of power as a starting point” (p. 211) provides a closer link between theory and practice, making this applicable to empirical social health research. In this vein, while the focus of this study was on TB and immigrant health, the theoretical contributions extend beyond this substantive area and can be applied to study power relations between doctors and patients in a clinical setting in other contexts.

3 Implications for Clinical Practice

My analysis supports the findings of other studies (Nkulu Kalengayi et al., 2016) which shows that in the context of TB care, immigration logic detracts the focus from concerns over newcomers’ health to concerns over compliance with immigration requirements and biosecurity (i.e. eliminating the pathogenic source of ‘contamination’ or ‘danger’). This makes it difficult for both clinicians and immigrant patients for several reasons. First, the primary focus on biosecurity impedes TB specialists’ ability to effectively perform in their role as health care providers. As my analysis suggests, in the context of immigration, TB clinicians may not be fully aware of the
roles they play in relation to the patient as a CIC applicant. Health care providers regard TB immigration patients as regular patients with the understanding that there is a bureaucratic aspect involved once diagnosis is established. As such, while they do incorporate patient-centred care, some may be more inclined to conduct the health assessment as they would with any other patient by privileging the health and wellbeing of the patient over all other concerns (such as conditions of immigration and settlement). However, the medicalization of immigration shapes power relations in the clinical context in such a way that immigration TB patients have different objectives from those of a typical patient. For immigration TB patients, the bureaucratic aspect of the medical assessment is not an add-on, but rather is the only (or the main) purpose of the medical encounter.

Second, because most TB health care providers are unaware of their role in the immigration and settlement and CIC application process, they are not familiar with the policies and specific application requirements to communicate an applicant’s or immigrant’s medical clearance. My analysis showed significant gaps in communicating these requirements to TB specialists by both Panel Physicians (PPs) and CIC/IRCC. Such lack of transparency and information resulted in the submission of insufficient medical documentation (i.e. missing chest x-rays, insufficient notation, etc.) from TB specialists to PPs in the context of domestic IME screening, which unintentionally caused delays in the application process for some participants. As such, TB clinicians providing medical services to CIC applicants should familiarize themselves with immigration policies and application procedures to ensure that the immigration process is not complicated for the patient. Likewise, as it is the PP’s responsibility to communicate to TB specialists what documentation and medical evidence is necessary to complete the TB health screening process of immigration applicants (CIC, 2016a), they must ensure to provide this information in the referral prior to the assessment, and also follow-up with the TB clinicians if any documentation is missing.

Third, the concern over becoming the ‘desirable’ immigrant affects the therapeutic decisions of individual patients in unexpected ways. For instance, given global epidemiological TB data, if newcomers are at an increased risk of reactivation of latent infection as argued by the WHO (2014a), from a clinical and public health standpoint, prophylaxis is considered the most reasonable option. Unfortunately, as noted by others (Nkulu Kalengayi et al., 2016), due to concern over the status of their immigration application, some newcomers may be less inclined
to undergo preventative treatment due to fears of how this decision might be interpreted by immigration authorities despite assurances from clinicians that it has no bearing on their immigration status. The opposite may also be true; some newcomers may fear that their decision to reject prophylaxis will be negatively perceived by immigration officials and will jeopardize their immigration application, leading immigration TB patients to accept preventative treatment when they otherwise may not have. For others still, the immigration and settlement process itself may influence their therapeutic decisions and health related practices. Given the experience of compulsory repeated TB health screening in the context of immigration, some newcomers may experience ‘procedural burnout’ to the point where they may be unwilling to undergo yet another round of medical tests to confirm LTBI and potentially begin preventative treatment, even when such measures are framed by clinicians as being in the interest of ‘their own health’. On the other hand, some newcomers may be overwhelmed with trying to reestablish their lives in a new country (i.e. finding work, housing, school, building relationships with family after reuniting with them in Canada, attending to more pressing health issues that have been neglected in the context of immigration, etc.) and may simply not perceive an asymptomatic dormant infection as a priority in the context of resettling in a new country. As similarly argued by others, in light of these results, it is rational to assume that if prophylaxis is an effective and desirable strategy to controlling and preventing TB among Canadian immigrants, the uptake of preventative treatment would be better among this population if this option was presented outside the context of immigration “when migrants are linked into health services” (Aldridge et al., 2016, p. 2517) in their destination countries. All these previously unknown concerns should be taken into consideration when providing medical care to immigration TB patients.

4 Implications for Policy

This study has several implications for both immigration and public health policy. First, while it is rational to continue screening applicants for active infectious TB disease in the interest of reducing global disease transmission, this study suggests that the rationale as well as the policies informing the organization, structure, and specific practices around immigration health screening in Canada warrant review. Current research indicates conflicting recommendations about screening immigration applicants for TB in low- and middle-income countries prior to departure to high-income nations. Some argue in favour of large-scale pre-departure TB screening
programs in source countries (i.e. Aldridge et al., 2014; Aldridge et al., 2016; Douglas et al., 2017), while others problematize the practice, pointing out the inefficiencies and challenges associated with the immigration health screening process (i.e. Asadi et al., 2017; Hargreaves et al., 2016; Kehr, 2012, Khan et al., 2015). Both have compelling arguments. Most notably, Douglas et al. (2017) support pre-entry TB screening programs established in high-TB-burden countries by immigrant-receiving nations, contending that they are actually beneficial for controlling TB globally as they can set up the precedent for capacity-building through public health promotion and can contribute to the development of laboratory and treatment capabilities in source countries; this argument is supported by Wickramage and Mosca (2014). From a global health perspective, if collaboration is established with public health and disease control agencies in the source countries (van der Werf & Lonnroth, 2014), this approach would be beneficial in many ways.

On the other hand, however, from the perspective of provision of care to immigrants after arrival in host countries, further expanding pre-departure TB screening programs would only serve to emphasize notions of biosecurity which perpetuate the discursive construction of immigrants as a ‘danger’ and source of contagion, providing further justification for discrimination and exclusion of applicants based on health status. This rationality is in direct opposition to the WHO’s position on the ethics of immigration TB screening, which contends that “[s]creening for either [active or latent TB in the context of immigration] should always be done with the intention to provide appropriate medical care, and never to exclude or preclude entry” (WHO, 2017b, p. 17). The more recent recommendations from not only the WHO (2014b), but also others (Asadi et al., 2017; Aldridge et al., 2014; Aldridge et al., 2016; Hargreaves et al., 2016; Kehr, 2012; Khan et al., 2015) suggest that instead of expanding immigration TB screening programs in low-incidence nations, which detect only a modest number of active TB cases among applicants (Asadi et al., 2017 and Khan et al., 2015 in Canada), the focus should be on developing post-immigration health services to integrate newcomers into the health care system. This would not only provide opportunities for prophylactic treatment of LTBI among newcomers, but would also simultaneously help to address other health needs of migrants that put them at a higher risk of reactivation of LTBI. While I support this recommendation, based on the results of this study I would suggest that offering prophylaxis to new immigrants should only take place after
immigration medical clearance has been approved and the immigration application process is complete.

The experiences of immigration applicants undergoing TB screening and surveillance as part of the immigration and settlement process reveals inefficiencies in the current system, which has further implications for immigration and public health policy. The analysis of participants’ accounts and their Migratory Pathways reveal that in Canada, newcomers face some of the barriers to care identified by Falzon et al. (2012), particularly “inadequate knowledge of, or coverage by, the health care services, … lack of money, … [and] concern and discrimination and fear of expulsion” (p. e7524-1). Study results indicate that confusion over medical testing requirements cause newcomers to unnecessarily undergo multiple health assessments in primary care, public health clinics, and TB specialist clinics, resulting in a waste of time, money, and efforts, all of which are scarce resources for newcomers trying to re-establish their lives in a new country. The numerous redundancies and inefficiencies in the system, particularly referral for IMS of in-Canada immigration applicants (as also noted by Khan et al., 2015) also reveal that the Canadian government is wasting resources, particularly in the Canadian health care system. While the current system is primarily set up to protect Canadians and help immigrants by detecting a serious infection and providing the opportunity for treatment, it paradoxically may negatively impact the health and wellbeing of newcomers to Canada.

As revealed through this study, part of the confusion and anxieties experienced by applicants and newcomers undergoing TB IMS stems from a lack of information about what the medical screening process entails. While they are the most distal authority figures encountered by applicants during the immigration process, TB specialists happened to be the main source of information about the TB screening and surveillance process and the requirements necessary for obtaining immigration medical clearance. Given that TB specialists were the least knowledgeable about immigration policies and typically encountered immigrants during the final steps along the Migratory Pathway, this is problematic. In light of these results, I argue that much of the distress and suffering experienced by applicants and newcomers can be either prevented or minimized if the steps to, expectations during, and implications of immigration TB screening and surveillance are officially communicated by CIC/IRCC to applicants and newcomers at the beginning of the immigration application process. This recommendation falls in line with the WHO’s position on providing individuals with “information and counseling about TB
prevention, diagnostics, treatment and care services” (WHO, 2017b, p. 11) as a duty and an integral part of patient-centred TB care and prevention.

Furthermore, I propose that a restructuring of the IMS process can reduce redundant medical testing and unnecessary health care spending by both newcomers and the government. Instead of referring newcomers to primary care for post-arrival TB medical assessments (where physicians are unfamiliar with clinical presentation of TB and immigration policies), specialized TB assessment clinical services should be designated for this population, ideally at a centralized immigrant health clinic. This would not only reduce the number of unnecessary medical exams through this process (which would reduce the financial burden on newcomers), but would also ensure that newcomers are assessed by TB specialists who are also more familiar with IMS requirements, and, as a result, are integrated into the Canadian health care system on more positive terms, providing opportunities to better address other health issues. This approach would arguably better align biomedical, public health and state objectives of TB medical screening and surveillance with newcomers’ individual goals.

5 Recommendations

In light of the results of this study, I propose the following recommendations:

1. Provide clear information and improve transparency about the immigration application process for CIC/IRCC applicants particularly around the requirements and steps to completing the medical screening and surveillance process for TB. This should include the following information: reasons for referral for TB Furtherance, what this process entails (including which tests are necessary), provide an estimated timeline needed to obtain a diagnosis, what documentation is required to complete the application, and outline the potential implications of different diagnostic outcomes (i.e. active pulmonary TB, active non-pulmonary TB, LTBI, other, etc.; referral for post-landing IMS) for the application process and immigration status. This information can be made available to applicants/newcomers through Panel Physicians’ clinics, Public Health units, and TB specialist clinics.
2. The Canadian government should inform all potential health care providers involved in screening and treating CIC applicants / IMS TB patients (i.e. TB specialists, other specialists, etc.) about their specific clinical and administrative roles in the immigration health screening and surveillance process. Furthermore, while these duties and responsibilities are outlined for Panel Members (PMs) (CIC, 2016a), a regulatory body should periodically review the performance of PMs to ensure that standards and expectations in this role are met.

3. As a follow-up to recommendation #2, since IME reports can now be submitted digitally through the eMedical system (CIC, 2016a), this system should be made available domestically to specialist TB clinics where CIC/IRCC applicants are referred for TB Furtherance. This would not only explicitly indicate what documentation is required for the purpose of the CIC/IRCC application (i.e. clinical notes, chest x-rays, laboratory test results, etc.), but would also enable assessing TB specialists to upload all required documentation without unnecessary delay. If this were made available in the context of TB IMS, a provincial or national eMedical system could consolidate immigration, public health, and clinical information, centralizing the TB prevention and control program.

4. Referring newcomers to primary care for TB IMS is redundant, inefficient, and wasteful. Instead, a centralized immigrant health clinic or health centre should be established to not only provide TB medical screening for immigration purposes (TB Furtherance and IMS), but also to assist with integrating newcomers into the Canadian health care system.

5. If the objective is to prevent the development of active TB disease in immigrant populations by encouraging uptake of chemoprophylaxis to treat LTBI (as per the WHO, 2014b), unless medically indicated otherwise, the option of preventative treatment for latent TB infection should be introduced to IME/IMS TB patients outside the context of immigration, after official documentation and CIC/IRCC confirmation of medical clearance has been provided to the applicant.

6. To prevent TB in immigrant populations domestically, the Canadian government should continue and expand global efforts aimed at improving detection and treatment of TB in resource-poor, high TB-incidence countries (Coussens et al., 2017; Posey et al., 2017).
6 Study Limitations & Future Directions

The major limitation of this study was the inclusion of a very small, narrowly defined subpopulation of immigrants undergoing TB immigration health screening and medical surveillance. This, in part, was due to multiple difficulties encountered during participant recruitment and problems accessing the population of interest, which resulted in having to shift the focus of the present study at the early stages of the research process. All study participants were adults, most were educated (college or higher), and most spoke English. Despite being at a socioeconomic and political disadvantage compared to non-migrant populations (i.e. most participants were not Canadian citizens and some were still waiting for immigration application approval), this group of participants is not representative of the most vulnerable subgroup of newcomers to Canada, particularly those most affected by TB. As such, only the perspectives and experiences of these newcomers are represented in the Migratory Pathways, limiting the transferability of findings to other subgroups of immigrants. However, if this group of newcomers who arguably have a better ability to exercise agency, navigate the immigration system, and negotiate interpersonal encounters due to their educational background and English fluency have reported substantial difficulties in their migratory journey, it suggests that many others would have a much more difficult immigration experience. This speculation could be explored by repeating a similar study with more vulnerable, albeit more difficult to access, immigrant groups.

Another limitation of this study is limiting recruitment and observations to one public health unit and one TB clinic. Given variances between regional public health units, different guidelines informing TB prevention and control programs, different immigrant populations, and different institutional norms and practices between TB clinics, it would be worthwhile to examine whether the experiences of TB IMS patients in this study differed from other newcomers referred for IMS in other clinics/regions/cities/provinces across Canada. Furthermore, building on the findings presented in this study, it would be useful to examine how much newcomers’ experiences undergoing TB IMS in a primary care setting differed from those assessed at a specialized TB clinic.

An unanticipated finding of this study was TB specialists’ lack of understanding and awareness of their role and involvement in the immigration and settlement process. While clinicians at the
study site reported knowing that they conduct medical assessments for the purpose of ‘immigration medical surveillance’, they were unaware that they also assessed CIC applicants at the IME stage. This study cleared up their confusion about having to medically assess the same individual twice for TB in the context of immigration (once during TB Furtherance at the IME stage, then a second time for IMS after the individual’s CIC application was approved). While I have made observations about how clinicians take up and exercise power during the clinical encounter, I interpreted these data primarily from the perspective of newcomers. As such, TB clinicians’ perspectives were not included in the present study. Given the critical role that health care providers play in the immigration process, future studies about immigration TB health screening and surveillance should include the perspectives of TB specialists and other health care providers involved in this process.

Lastly, the data collected during this study raises some questions for me, pointing to theoretically interesting directions for future research. During my analysis, I noticed other discourses operating, namely discourses of abuse (Eakin, 2005) and discourses of suspicion. These underlying discourses were observed not only during the CIC application process produced within the discursive frame of immigration, but also specifically in the context of the clinical encounter within the discursive frame of medicine. I noticed an underlying “juridical sense of authoritative judgment” (Tierney, 2004, p. 285) and “institutionalized mistrust” (Eakin, 2005, p. 159) aimed at applicants/patients both in immigration policy discourses and through medical practices, which preconstructed applicants as untrustworthy and attempting to misrepresent themselves (i.e. intentionally hide known TB diagnoses) on the CIC application and to assessing physicians. Because immigration policies assume that abnormal chest x-rays (or country of origin) are indicative of TB infection, the applicant is exhorted to prove their innocence, implicating medical experts in determining and legitimizing the veracity of applicant’s claims. This juridical dimension of the medical case has been investigated through a governmentality framework in the context of constructing the ‘medical case’ (Tierney, 2004), but it has not, as yet, been applied in the context of TB immigration medical surveillance. It would be a worthwhile intellectual pursuit to examine the role of these discourses on the production of subjectivities in the context of TB, as well as at the articulation of immigration and medical discursive fields.
Concluding Remarks

In the Federal Framework for Action towards TB Prevention and Control in Canada (PHAC, 2014b), it is claimed that CIC “deliver[s] health care services to” newcomers, and that this federal government department, along with others, is responsible for implementing the federal plan into action (p. 5). The results of this study suggest otherwise. Given that the practice of immigration health screening and TB surveillance is underpinned by concerns around the biosecuritization of borders, I contend that from the perspective of the state, the TB public health and medical practices directed at immigrants are more about the managerial control of ‘contaminated’ foreign bodies rather than the provision of medical care to some of the most vulnerable social groups in Canada. Furthermore, the exclusion of foreign ‘contaminating’ bodies, the surveillance of ‘contaminated’ foreign bodies, and the focus on prophylactic treatment of LTBI is reinforced by, and further reinforces, the biomedical emphasis on the distinction between “normality and pathology” (Rose, 1994, p. 57); it also perpetuates stigma towards applicants identified as ‘potentially infected’. This rationality reduces the understanding of TB and disease causation to the level of the individual, framing the possibilities for interventions and solutions as proximal and strictly in biomedical terms. While a public health strategy that focuses on the biological conceptualization of the disease process is important for treating active TB disease, privileging biomedical logics over all others marginalizes the perspectives and experiences of newcomers and can exacerbate health inequities, raising social justice concerns with health:

This increasing power of scientific medicine, it is contended, has detrimental effects for traditionally disempowered and exploited social groups by deflecting questions of social inequality into the realm of illness and disease, there to be treated inappropriately by drugs and other medical therapies. (Lupton, 1997, p. 96)

Biomedical logic, which promotes a curative approach to TB (particularly with regard to preventative treatment of LTBI), ignores the social and economic conditions of people’s lives that make the proliferation of this disease possible. I argue that an overemphasis on biomedical approaches to treating TB merely in the name of biosecuritization does little for actually controlling and eradicating TB in Canada. While I agree with Khan et al. (2015) that immigration screening for active TB may be valuable if targeted at truly vulnerable and high-risk populations,
consistent with the recommendations of the WHO (2014a) on the prevention and care for TB among migrants, this study highlights the dire need to incorporate a social determinants of health approach, particularly one that acknowledges the immigration and settlement process itself as a determinant of TB and immigrant health.

As Falzon et al., (2012) suggest, instead of conceptualizing migration as a threat due to the ‘importation of disease’, this should be viewed as an “opportunity to improve detection and treatment outcomes of TB cases in the world” (p. e7524-6). This could be operationalized in several ways. For instance, for applicants from countries with a low TB burden, instead of mandating TB screening and surveillance as a condition of entry (which has been shown in this study to results in stigma, fear, and potential suffering), reframing TB screening as an ‘opportunity’ for the detection of a potentially serious disease may encourage uptake of this health service (Brewin et al., 2006; Falzon et al., 2012), resulting in better overall health outcomes. Second, centralizing health services for newcomers, particularly for TB IMS medical assessments, would be also likely be beneficial; such an approach would not only streamline the medical surveillance process, saving money and other resources for both the Canadian government and new immigrants, but would also provide the opportunity for inserting newcomers into the Canadian health care system. Furthermore, in a contemporary world where the global and local are intimately intertwined, an approach to national TB control underpinned by the rationality of border policing that prioritizes exclusionary immigration policies is myopic and not an effective long-term solution. In contrast to the WHO’s (2014a) recommendations, this study suggests that the current immigration health screening and TB surveillance system creates administrative barriers and, while it may increase access to health services for newcomers, it actually obstructs the delivery of care to newcomers at highest risk for TB.

TB does not respect borders. To control TB locally, global action is required. I contend that the most effective strategy for eradicating TB in Canada requires both optimization of current TB control efforts by including a social determinants approach to the delivery of TB care and interventions for newcomers, as well as continued involvement in and contribution to global TB prevention and control efforts. While it is rational to fear TB as an infectious disease, we should not forget that those infected with TB are victims themselves. Instead of punishing and shunning the ‘contaminated others’, we, as a society, need to transform our perspective and start recognizing these immigrants as not only social citizens and Canadians, but most importantly as
humans. With the knowledge and technology available to us in the 21st century, there is no excuse for medicalized prejudice. To borrow from Farmer (1999), in addressing infectious diseases, let's not only act medically, but sociologically as well.
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Appendices

Appendix A  Research Ethics Boards Approval Letters

Research Ethics Office
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May 7, 2015

Dr. Jane Batt
Department of Medicine, Division of Respirology
St Michael's Hospital

Dear Dr. Batt,

Re: REB# 14-380C - Social Perspectives on Tuberculosis and immigration

REB APPROVAL: Original Approval Date  May 07, 2015
Annual/Interval Review Date  May 07, 2016

Thank you for your application submitted on 14 November, 2014. The above noted study has been reviewed through a delegated process (not by Full Board review). The views of the St. Michael's Hospital (SMH) Research Ethics Board (REB) have been documented and resolved. Please note that no member of the St. Michael's Hospital Research Ethics Board associated with this study was involved in its review or approval.

The REB approves the study as it is found to comply with relevant research ethics guidelines, as well as the Ontario Personal Health Information Protection Act (PHIPA), 2004. The REB hereby issues approval for the above named study for a period of 12 months from the date of this letter. Continuation beyond that date will require further review of REB approval. In addition, the following documents have been reviewed and are hereby approved:

1. Protocol - ver: 3/16/2015
2. Questionnaire - Socio-Demographic Questionnaire: Stage 1 ver: 11/13/2014
3. Questionnaire - Socio Demographic Questionnaire: Stages 2 and 3 ver: 3/16/2015
4. Consent form - Stage 1 ver: 3/16/2015
5. Consent form - Stage 2 and 3 ver: 3/16/2015
6. Consent form - TB Clinic Staff ver: 3/16/2015
7. Staff Recruitment Email ver: 3/16/2015

Furthermore, the following documents have been received and are acknowledged:

1. Master Linking Log - ver: 3/16/2015

During the course of this investigation, any significant deviations from the approved protocol and/or unanticipated developments or significant adverse events should immediately be brought to the attention of the REB.

Please note that if a Clinical Trial Agreement is required, it must be submitted to the Office of Research Administration for review and approval. Any additional institutional approvals must be coordinated and approved through the Office of Research Administration prior to initiation of this research. All drug dispensing must be coordinated through the Research Pharmacy at 416-864-5413.

The St. Michael's Hospital (SMH) Research Ethics Board (REB) operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans, the Ontario Personal Health Information Protection Act, 2004, and ICH Good Clinical Practice Consolidated Guideline.
E6. Health Canada Part C Division 5 of the Food and Drug Regulations, Part 4 of the Natural Health Product Regulations, and the Medical Devices regulations. Furthermore, all investigational drug trials at SMH are conducted by Qualified Investigators (as defined in the latter document).

With best wishes

Dr. David Mazer
Chair, Research Ethics Board

Dr. Philip Berger
Vice Chair, Research Ethics Board

Dr. Brenda McDowell
Vice Chair, Research Ethics Board
PROTOCOL REFERENCE # 31723

June 16, 2015

Dr. Denise Gastaldo
FACULTY OF NURSING

Ms. Martyna A. Janjua
FACULTY OF NURSING

Dear Dr. Gastaldo and Ms. Martyna A. Janjua,

Re: Your research protocol entitled, "Social perspectives on tuberculosis and immigration"

ETHICS APPROVAL

Original Approval Date: June 16, 2015
Expiry Date: June 15, 2016
Continuing Review Level: 1

We are writing to advise you that the Health Sciences Research Ethics Board (REB) has granted approval to the above-named research protocol under the REB's delegated review process. Your protocol has been approved for a period of one year and ongoing research under this protocol must be renewed prior to the expiry date.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events in the research should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your current ethics approval. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry.

If your research is funded by a third party, please contact the assigned Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your research.

Yours sincerely,

Elizabeth Peter, Ph.D.
REB Chair

Dario Kuzmanovic
REB Manager

OFFICE OF RESEARCH ETHICS
McMurrich Building, 12 Queen's Park Crescent West, 2nd Floor, Toronto, ON M5S 1S8 Canada
Tel: +1 416 946-3273 • Fax: +1 416 946-5763 • ethics.review@utoronto.ca • http://www.research.utoronto.ca/for-researchers-administrators/ethics/
March 22, 2016

Ms. Martyna Janjua
Dalla Lana School of Public Health
University of Toronto
155 College Street
Toronto, Ontario
M5T 3M7

Dear Ms. Janjua,

Re: Social Perspectives on Tuberculosis and Immigration [File Number 2015-23]
Principal Investigator: Ms. Martyna Janjua

I am writing to advise you that the Toronto Public Health Research Ethics Board (TPH REB) has reviewed and approved the research proposal referenced above for a period of one year, until March 22, 2017. If the study is expected to continue beyond this date you will need to complete a Continuing Research Renewal Form by February 22, 2017 and forward it to the REB or your ethics approval will expire.

If changes are made to the approved research proposal, implementation protocols, and/or consent materials an amendment form will need to be submitted to the REB for review and approval prior to implementation. Any adverse or unanticipated issues or events that occur during the course of the study that may increase the level of participants’ risk or have other ethical implications that may affect participants’ welfare (e.g., unexpected reactions by participants, unavoidable single incidents, inappropriate/unauthorized use of information, privacy breaches) must be reported to the REB immediately.

Upon completion of the project an End of Research Project Reporting Form and a final report must be submitted to the REB. All relevant forms are available on the Toronto Public Health Research Ethics Review website.

Best wishes for the successful completion of your project.
Yours sincerely,

Heather Sampson
Chair, Toronto Public Health Research Ethics Board

Enclosures: Flyer Version B, February 11, 2016 Version
    Recruitment Script 2, March 9, 2016 Version
    Consent to Participate in a Research Study, March 9, 2016 Version
    Interview Introductory Script, March 9, 2016 Version

cc    Dr. Denise Gastaldo
      Dr. Barbara Yaffe
      Megan Easto
      File #2015-23
Appendix B  TB Clinic Staff Consent Form

St. Michael’s
Inspired Care. Inspiring Science.

Consent to Participate in a Research Study (TB Clinic Staff)
Study Title: Social Perspectives on Tuberculosis and Immigration

Principal Investigator: Dr. Jane Batt, MD PhD, Medical Director of Tuberculosis Program, St. Michael’s Hospital

Co-Investigator: Martyna A. Janjua, MA, Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto

Introduction
Before agreeing to take part in this study, it is important that you read the information in this research consent form. It includes details we think you need to know in order to decide if you wish to take part in the study. If you have any questions, ask the study doctor or student researcher. You should not sign this form until you are sure you understand the information. Your participation in this study is completely voluntary.

Investigators
For questions or more information concerning this research you may contact the study doctor, student researcher or her supervisor:
• Principal Investigator / Study Doctor: Dr. Jane Batt, MD PhD (Medical Director, Tuberculosis Program, St. Michael’s Hospital), available through St. Michael’s Hospital locating at (416) 864-5431 24 hours a day.
• Co-Investigator / Student Researcher: Martyna Janjua, MA (Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto), available by telephone at or by email at martyna.janjua@mail.utoronto.ca.
• Student Researcher’s Doctoral Thesis Supervisor: Dr. Denise Gastaldo, PhD (Associate Professor, Bloomberg Faculty of Nursing and Dalla Lana School of Public Health, University of Toronto), available by telephone at (416) 978-4953, or by email at denise.gastaldo@utoronto.ca.

Conflict of Interest
We, the Study Doctor, Student Researcher and Student’s Supervisor declare that we have no competing interests arising as a result of our involvement in this study.

Study Funder
This study is funded by the Social Science and Humanities Research Council (SSHRC) Joseph-Armand Bombardier Canada Graduate Doctoral Scholarship (Award No. 767-2009-1190).

Purpose of Study
The purpose of this qualitative study is to understand how newcomers experience the process of disease surveillance for tuberculosis (TB) during their immigration and settlement process. This study will provide insights into how and under what conditions immigrants receive their diagnosis of latent tuberculosis (LTBI). Specifically, it will document the challenges and
struggles associated with the processes of immigration and settlement while concurrently being diagnosed with a stigmatizing health condition that results in the integration of newcomers into a system of surveillance and management. The results of this study will help to understand the consequences of being labeled as “sick” within a larger context of the immigration journey of newcomers. This research is part of a doctoral dissertation in Public Health at the University of Toronto. It is NOT organized by St. Michael’s Hospital or Citizenship and Immigration Canada.

The population of interest are immigrants from anywhere in the world who speak English, Mandarin, Cantonese or Hindi who have been referred to the St. Michael’s Hospital TB Clinic as part of their Immigration Medical Examination. You are being contacted about this study because you are part of the Tuberculosis Clinic staff at St. Michael’s Hospital and are directly or indirectly involved in providing medical services and assessments to this population. This study is NOT an evaluation of the TB program at St. Michael’s Hospital or the performance of any of its staff.

Description of the Study Procedures
Data will be collected for this study through observation of TB Clinic appointments at St. Michael’s Hospital and interviews with TB Clinic patients. You are being asked to participate only in the observation stage of the study. If you agree to be in this study, you do not have to do anything differently. The student researcher will sit quietly and observe: 1) first assessments and interviews with incoming patients, and 2) follow-up appointments with returning patients who have confirmed LTBI. You will not be asked any questions or interrupted in any way by the student researcher during the appointments. The conversations you have with the patients during these appointments will be audio recorded. The student researcher will step out of the room when physical exams will be conducted; however, the audio recorder will be left in the room to record any conversations during this time. You may be contacted by the student researcher if there is a need to clarify any information collected during the appointments with patients. The student researcher will be present during regular TB Clinic hours to collect data for a period of approximately 4 months. Once observational data is collected your participation in this study is completed.

Potential Harms / Risks of Being in the Study
There are no reasonable foreseeable risks. This study may include other risks that are unknown at this time.

Potential Benefits of Being in the Study
There will be no direct benefits to you from participating in this study. However, information learned through this study may prove useful in addressing issues related to TB testing, diagnosis and treatment, as well as access to services for this population in the future.

Confidentiality
Any personal information collected during this study will not be used in a way that could identify you. We will not use your real name in any written reports. If any additional information about you must be disclosed, it will only be done so with your permission or as required by law. The de-identified information we collect about you will be used for a doctoral thesis, published
research papers and conference presentations, and may be presented at seminars or other public forums or may be used for teaching purposes.

Research records will be kept secure in a locked file. All electronic information will be encrypted and secured using a password-protected file. Only the student researcher and her thesis supervisor (Dr. Denise Gastaldo) will have access to audio recordings. Anonymized and de-identified research records will be stored for five years following the completion of the study in accordance with St. Michael’s Hospital policy. These records will be stored by the student researcher securely as password-protected files.

The information collected for this study may be seen by the Research Ethics Boards at St. Michael’s Hospital and at the University of Toronto for monitoring purposes. A representative of the Research Ethics Board may contact you to ask questions about your experience with the recruitment and consent process, or about your experience in this study, to make sure that the investigators followed all procedures correctly.

Study Results
You will not be directly informed of the study results. If you wish to have a summary of the results of this study you may contact any of the investigators (study doctor, student researcher, or student’s supervisor) upon completion of the student’s doctoral thesis in December, 2015.

Costs and Reimbursement to the Participant
There is no cost to you to participate in this research study. You will not receive any payments or reimbursement for participating.

Participation and Withdrawal
Your participation in any research study is voluntary. If you choose not to participate, it will NOT affect your employment or professional standing at St. Michael’s Hospital or any other institution in any way, today or in the future. You are free to withdraw at ANY TIME, for whatever reason. If you choose to withdraw you do NOT have to say why. There is no penalty to you for not taking part or for stopping your participation. If you withdraw from the study, all information collected up to that point will be kept and used in the study. You will not be contacted in the future for any additional data collection.

Research Ethics Board Contacts
If you have any questions about your rights as a research participant, you may contact the Research Ethics Board (REB) at St. Michael’s Hospital at (416) 864-6060 x 2557 during business hours or at the University of Toronto (416) 946-3273 (ethics.review@utoronto.ca). The REB is a group of people who oversee the ethical conduct of research studies. They are not part of the study team. Everything that you discuss with them will be kept confidential.

The study protocol and consent form have been reviewed by a committee called the Research Ethics Board at St. Michael’s Hospital. The Research Ethics Board is a group of scientists, medical staff, individuals from other backgrounds (including law and ethics) as well as members from the community. The committee is established by the hospital to review studies for their
scientific and ethical merit. The Board pays special attention to the potential harms and benefits involved in participation to the research participant, as well as the potential benefit to society.

This committee is also required to do periodic review of ongoing research studies. As part of this review, someone may contact you from the Research Ethics Board to discuss your experience in the research study.

Statement of Consent
The research study has been explained to me, and my questions have been answered to my satisfaction. I have been informed of the alternatives to participation in this study. I have the right not to participate and the right to withdraw without affecting the quality of medical care at St. Michael’s Hospital for me and for other members of my family. As well, the potential harms and benefits (if any) of participating in this research study have been explained to me.

I have been told that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional responsibilities. I know that I may ask now, or in the future, any questions I have about the study. I have been told that records relating to me and my care will be kept confidential and that no information will be disclosed without my permission unless required by law. I have been given sufficient time to read the above information.

I consent to participate. I have been told I will be given a signed copy of this consent form.

Study Participant’s Name __________________________ Signature __________________________ Date ______________

My signature means that I have explained the study to the participant named above. I have answered all questions. I attest that consent was given voluntarily.

Name of person obtaining consent __________________________ Signature __________________________ Date ______________
Appendix C  TB Clinic Recruitment: Participant Consent Forms

St. Michael's
Inspired Care. Inspiring Science.

Consent to Participate in a Research Study
Study Title: Social Perspectives on Tuberculosis and Immigration
(Stage 1: Clinical Observation)

Principal Investigator: Dr. Jane Batt, MD PhD, Medical Director of Tuberculosis Program, St. Michael’s Hospital

Co-Investigator: Martyna A. Janjua, MA, Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto

Translators: Michelle X. Xin (Mandarin/Cantonese)  Jing Zhao
(Mandarin/Cantonese)  Bhoomika Pipiani (Hindi)

Introduction
Before agreeing to take part in this study, it is important that you read the information in this research consent form. It includes details we think you need to know in order to decide if you wish to take part in the study. If you have any questions, ask the study doctor or student researcher. You should not sign this form until you are sure you understand the information. Your participation in this study is completely voluntary.

Investigators
For questions or more information concerning this research you may contact the study doctor, student researcher or her supervisor:
• Principal Investigator / Study Doctor: Dr. Jane Batt, MD PhD (Medical Director, Tuberculosis Program, St. Michael’s Hospital), available by telephone through the St. Michael’s Hospital operator at (416) 864-5431 24 hours a day. Inform the operator you are a study participant and ask them to page Dr. Batt.
• Co-Investigator / Student Researcher: Martyna Janjua, MA (Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto), available by telephone at or by email at martyna.janjua@mail.utoronto.ca.
• Student Researcher’s Doctoral Thesis Supervisor: Dr. Denise Gastaldo, PhD (Associate Professor, Bloomberg Faculty of Nursing and Dalla Lana School of Public Health, University of Toronto), available by telephone at (416) 978-4953, or by email at denise.gastaldo@utoronto.ca.

Conflict of Interest
We, the Study Doctor, Student Researcher and Student’s Supervisor declare that we have no competing interests arising as a result of our involvement in this study.

Study Funder
This study is funded by the Social Science and Humanities Research Council (SSHRC) Joseph-Armand Bombardier Canada Graduate Doctoral Scholarship (Award No. 767-2009-1190).

Social Perspectives on TB and Immigration (Stage 1), Version Date Mar. 16, 2015
Purpose of Study
The purpose of this study is to understand how being tested for tuberculosis (TB) during immigration affects you personally as a newcomer. Your experience is unique and valuable. It can help doctors and others working with new immigrants understand how to better help newcomers after they move to Canada. Doctors and researchers know a lot about TB, but what is not well documented is the perspectives or experiences of newcomers who have to be tested for TB after coming to Canada. This research is part of a doctoral thesis in Public Health at the University of Toronto. It is NOT organized by St. Michael’s Hospital or Citizenship and Immigration Canada (CIC).

You were selected as a possible participant because you were referred to the St. Michael’s Hospital TB Clinic as part of your Immigration Medical Examination. Participants in this study are immigrants from anywhere in the world who speak English, Mandarin, Cantonese or Hindi. If you are entering Canada as a refugee, temporary migrant worker or temporary student, or are not seeking to permanently immigrate to Canada you do not qualify for this study.

Description of the Study Procedures
You are being asked to participate in the first stage of the study, which is observation of your first TB Clinic visit at St. Michael’s Hospital to better understand the clinic procedures and what happens during this visit. Six (6) people will be enrolled in this stage of the study. If you agree to be in this study at this stage, you will be asked to fill out a short questionnaire asking for information like your age, where you come from etc. before you begin your appointment. Your appointment at the Tuberculosis Clinic today will not be any different than if you did not participate in the study. The student researcher will sit quietly and observe your appointment today. You will not be asked any questions by the student researcher and you will not be asked to perform any tests. The student researcher will NOT have access to your medical records or your immigration records.

The conversations you have with the Tuberculosis Clinic staff during your appointment will be audio recorded. The student researcher will step out of the room during your physical exam with the clinic doctor to give you privacy, but the conversations you have with the doctor at this time will continue to be audio recorded. Once your appointment at the clinic today is finished your participation in this study is completed. You will not be contacted in the future about this study.

Potential Harms / Risks of Being in the Study
Experience in similar studies indicates that the greatest risk in this study to you is the unintentional release of information from your study records. The study doctor and student researcher will protect your records and keep confidential any information collected, including your name, address and telephone number. The chance that this information will accidentally be given to someone else is small.

Because the student researcher will be present during your appointment, she will hear your private medical history, which may be uncomfortable for you and may cause some anxiety. This will be different for every individual. This study may also include other risks that are unknown at this time.
Potential Benefits of Being in the Study
The purpose of the study is to better understand how newcomers to Canada experience being tested for tuberculosis during the process of immigration. There will be no direct benefits to you from participating in this study. However, information learned through this study may help provide future immigrants with better care during tuberculosis testing or access to services.

Confidentiality
Your health or personal information collected during this study will not be used in a way that could identify you. We will not use your real name in any written reports. If any additional information about you must be disclosed, it will only be done so with your permission or as required by law. The de-identified information we collect about you will be used for a doctoral thesis, published research papers and conference presentations, and may be presented at seminars or other public forums or may be used for teaching purposes.

Research records will be kept secure in a locked file. All electronic information will be coded and secured using a password-protected file. Only the student researcher and her thesis supervisor (Dr. Denise Gastaldo) will have access to audio recordings. Anonymized and de-identified research records will be stored for five years following the completion of the study in accordance with St. Michael’s Hospital policy. These records will be stored by the student researcher securely as password-protected files.

The information collected for this study may be seen by the Research Ethics Boards at St. Michael’s Hospital and at the University of Toronto for monitoring purposes. A representative of the Research Ethics Board may contact you to ask questions about your experience with the recruitment and consent process, or about your experience in this study, to make sure that the investigators followed all procedures correctly.

Study Results
You will not be directly informed of the study results. If you wish to have a summary of the results of this study you may contact any of the investigators (study doctor, student researcher, or student’s supervisor) upon completion of the student’s doctoral thesis in May, 2016.

Costs and Reimbursement to the Participant
There is no cost to you to participate in this research study. You will not receive any payments or reimbursement for participating.

Participation and Withdrawal
Your participation in any research study is voluntary. If you choose not to participate, it will NOT affect your access to any medical care at St. Michael’s Hospital today or in the future. It will also NOT affect your immigration status with CIC in any way. You are free to withdraw at ANY TIME, for whatever reason. If you choose to withdraw you do NOT have to say why. There is no penalty or loss of benefits to you or your family for not taking part or for stopping your participation. If you withdraw from the study, all information collected up to that point will be kept and used in the study. You will not be contacted in the future for any additional data collection.
Research Ethics Board Contacts
If you have any questions about your rights as a research participant, you may contact the Research Ethics Board (REB) at St. Michael’s Hospital at (416) 864-6060 x 2557 during business hours or at the University of Toronto (416) 946-3273 (ethics.review@utoronto.ca). The REB is a group of people who oversee the ethical conduct of research studies. They are not part of the study team. Everything that you discuss with them will be kept confidential.

The study protocol and consent form have been reviewed by a committee called the Research Ethics Board at St. Michael’s Hospital. The Research Ethics Board is a group of scientists, medical staff, individuals from other backgrounds (including law and ethics) as well as members from the community. The committee is established by the hospital to review studies for their scientific and ethical merit. The Board pays special attention to the potential harms and benefits involved in participation to the research participant, as well as the potential benefit to society. This committee is also required to do periodic review of ongoing research studies. As part of this review, someone may contact you from the Research Ethics Board to discuss your experience in the research study.
Study Title: Social Perspectives on Tuberculosis and Immigration  
(Stage 1: Clinical Observation)

Principal Investigator: Dr. Jane Batt, MD PhD, Medical Director of Tuberculosis Program, St. Michael’s Hospital, (416) 864-5431

Co-investigator: Martyna A. Janjua, MA, Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto, , martyna.janjua@mail.utoronto.ca

Translators: Michelle X. Xin (Mandarin/Cantonese) ; Jing Zhao (Mandarin/Cantonese) ; Bhoomika Piplani (Hindi)

Statement of Consent
The research study has been explained to me, and my questions have been answered to my satisfaction. I have been informed of the alternatives to participation in this study. I have the right not to participate and the right to withdraw without affecting the quality of medical care at St. Michael’s Hospital for me and for other members of my family. As well, the potential harms and benefits (if any) of participating in this research study have been explained to me.

I have been told that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional responsibilities. I know that I may ask now, or in the future, any questions I have about the study. I have been told that records relating to me and my care will be kept confidential and that no information will be disclosed without my permission unless required by law. I have been given sufficient time to read the above information.

I consent to participate. I have been told I will be given a signed copy of this consent form.

_________________________  _________________________  ________________
Study Participant’s Name       Signature        Date

My signature means that I have explained the study to the participant named above. I have answered all questions. I attest that consent was given voluntarily.

_________________________  _________________________  ________________
Name of person obtaining consent Signature        Date

(continue if applicable)
Was the participant assisted during the consent process? □ YES □ NO
If YES, please check the relevant box and complete the signature space below:
Consent to Participate in a Research Study
Study Title: Social Perspectives on Tuberculosis and Immigration
(Stage 2&3: Clinical Observation and Interviews)

Principal Investigator: Dr. Jane Batt, MD PhD, Medical Director of Tuberculosis Program, St. Michael’s Hospital

Co-Investigator: Martyna A. Janjua, MA, Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto

Translators: Michelle X. Xin (Mandarin/Cantonese) ; Jing Zhao (Mandarin/Cantonese) ; Bhoomika Pipmani (Hindi)

Introduction
Before agreeing to take part in this study, it is important that you read the information in this research consent form. It includes details we think you need to know in order to decide if you wish to take part in the study. If you have any questions, ask the study doctor or student researcher. You should not sign this form until you are sure you understand the information. Your participation in this study is completely voluntary.

Investigators
For questions or more information concerning this research you may contact the study doctor, student researcher or her supervisor:
• Principal Investigator / Study Doctor: Dr. Jane Batt, PhD, MD (Director, Tuberculosis Program, St. Michael’s Hospital), available by telephone through the St. Michael’s Hospital operator at (416) 864-5431, 24 hours a day. Ask them to page Dr. Batt.
• Co-Investigator / Student Researcher: Martyna Janjua, MA (Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto), available by telephone at , or by email at martyna.janjua@mail.utoronto.ca.
• Student Researcher’s Doctoral Thesis Supervisor: Dr. Denise Gastaldo, PhD (Associate Professor, Bloomberg Faculty of Nursing and Dalla Lana School of Public Health, University of Toronto), available by telephone at , or by email at denise.gastaldo@utoronto.ca.

Conflict of Interest
We, the Study Doctor, Student Researcher and Student’s Supervisor declare that we have no competing interests arising as a result of our involvement in this study.

Study Funder
This study is funded by the Social Science and Humanities Research Council (SSHRC) Joseph-Armand Bombardier Canada Graduate Doctoral Scholarship (Award No. 767-2009-1190).
Purpose of Study
The purpose of this study is to understand how being tested for tuberculosis (TB) during immigration affects you personally as a newcomer. Your experience is unique and valuable. It can help doctors and others working with new immigrants understand how to better help newcomers after they move to Canada. Doctors and researchers know a lot about TB, but what is not well documented is the perspectives or experiences of newcomers who have to be tested for TB after coming to Canada. This research is part of a doctoral thesis in Public Health at the University of Toronto. It is NOT organized by St. Michael’s Hospital or Citizenship and Immigration Canada (CIC).

You were selected as a possible participant because you were referred to the St. Michael’s Hospital TB Clinic as part of your Immigration Medical Examination. Participants in this study are immigrants from anywhere in the world who speak English, Mandarin, Cantonese or Hindi. If you are entering Canada as a refugee, temporary migrant worker or temporary student, or are not seeking to permanently immigrate to Canada you do not qualify for this study.

Description of the Study Procedures
You are being asked to participate in the second and third stage of the study. Stage 2 of this study is observation of your follow-up visit at the Tuberculosis Clinic at St. Michael’s Hospital to better understand the clinic procedures and what happens during this visit. Approximately twelve (12) people will be enrolled in this part of the study. If you participate, you will be asked to fill out a short questionnaire asking for information like your age, where you come from, some information about your immigration and your Immigrant Medical Examination (IME) before your appointment starts. Your appointment at the Tuberculosis Clinic today will not be any different than if you did not participate in the study. The student researcher will sit quietly and observe your appointment. During your scheduled appointment the student researcher will NOT ask you any questions or ask you to perform any tests. The conversations you have with the Tuberculosis Clinic staff during your appointment will be audio recorded. The student researcher will NOT have access to your medical records or your immigration records.

Once your appointment at the clinic today is finished, you MAY be asked to take part in Stage 3 of this study, which includes asking you questions about TB and immigration to better understand your experience with TB testing as a newcomer. At this stage you will be asked to participate in two (2) interviews (lasting 60-90 minutes each) at another time. One interview will take place sometime next week, and the second interview will take place in two weeks (at a specific day and time that is convenient for you). During these interviews you will be asked about how and why you decided to come to Canada, what you know about TB, and about being tested for TB. These interviews will be audio recorded. If you do not wish to have your answers recorded, please tell me. I will not record them. These meetings will NOT take place at St. Michael’s Hospital. They may take place in a private office at the University of Toronto or another quiet place where you feel comfortable talking about your experiences with TB and immigration. Both you and the student researcher will agree on the exact time and place to meet for interviews. If you do not speak English, an interpreter will be provided to act as a translator during the interviews.
Potential Harms / Risks of Being in the Study
Experience in similar studies indicates that the greatest risk in this study to you is the unintentional release of information from your study records. The study doctor and student researcher will protect your records and keep confidential any information collected, including your name, address and telephone number. The chance that this information will accidentally be given to someone else is small.

Because the student researcher will be present during your appointment, she will hear your private medical history, which may be uncomfortable for you and may cause some anxiety. Talking about your experience of TB may make you uncomfortable or upset, but it may help some people feel better. This will be different for every individual. This study may also include other risks that are unknown at this time.

If for any reason you feel distressed as a result of your participation in this study and you feel that you need to talk to someone, you may contact the Distress Centre (416-408-HELP (4357)) or Gerstein Centre (416-929-5200). These are confidential local programs designed to help address any mental and physical health concerns and provide emotional and physical support by telephone.

Potential Benefits of Being in the Study
The purpose of the study is to better understand how newcomers to Canada experience being tested for tuberculosis during the process of immigration. There will be no direct benefits to you from participating in this study. However, information learned through this study may help provide future immigrants with better care during tuberculosis testing or access to services.

Confidentiality
Your health or personal information collected during this study will not be used in a way that could identify you. We will not use your real name in any written reports. If any additional information about you must be disclosed, it will only be done so with your permission or as required by law. The de-identified information we collect about you will be used for a doctoral thesis, published research papers and conference presentations, and may be presented at seminars or other public forums or may be used for teaching purposes.

Research records will be kept secure in a locked file. All electronic information will be coded and secured using a password-protected file. Only the student researcher and her thesis supervisor (Dr. Denise Gastaldo) will have access to audio recordings. Anonymized and de-identified research records will be stored for five years following the completion of the study in accordance with St. Michael’s Hospital policy. These records will be stored by the student researcher securely as password-protected files.

The information collected for this study may be seen by the Research Ethics Boards at St. Michael’s Hospital and at the University of Toronto for monitoring purposes. A representative of the Research Ethics Board may contact you to ask questions about your experience with the recruitment and consent process, or about your experience in this study, to make sure that the investigators followed all procedures correctly.
Study Results
You will not be directly informed of the study results. If you wish to have a summary of the results of this study you may contact any of the investigators (study doctor, student researcher, or student’s supervisor) upon completion of the student’s doctoral thesis in December, 2015.

Costs and Reimbursement to the Participant
There is no cost to you to participate in this study. You will not receive any payments today for taking part in today’s observations (Stage 2 of this study). If you are asked to participate in interviews (Stage 3) you will be given two Toronto Transit Commission (TTC) tokens to cover the cost of public transportation for each interview. You will also be paid $15 at the end of each interview ($30 total).

Participation and Withdrawal
Your participation in any research study is voluntary. If you choose not to participate, it will NOT affect your access to any medical care at St. Michael’s Hospital today or in the future. It will also NOT affect your immigration status with CIC in any way. You are free to withdraw at ANY TIME, for whatever reason. If you choose to withdraw you do NOT have to say why. There is no penalty or loss of benefits to you or your family for not taking part or for stopping your participation. If you withdraw from the study, all information collected up to that point will be kept and used in the study. You will not be contacted in the future for any additional data collection.

Research Ethics Board Contacts
If you have any questions about your rights as a research participant, you may contact the Research Ethics Board (REB) at St. Michael’s Hospital at (416) 864-6060 x 2557 during business hours or at the University of Toronto (416) 946-3273 (ethics.review@utoronto.ca). The REB is a group of people who oversee the ethical conduct of research studies. They are not part of the study team. Everything that you discuss with them will be kept confidential.

The study protocol and consent form have been reviewed by a committee called the Research Ethics Board at St. Michael’s Hospital. The Research Ethics Board is a group of scientists, medical staff, individuals from other backgrounds (including law and ethics) as well as members from the community. The committee is established by the hospital to review studies for their scientific and ethical merit. The Board pays special attention to the potential harms and benefits involved in participation to the research participant, as well as the potential benefit to society. This committee is also required to do periodic review of ongoing research studies. As part of this review, someone may contact you from the Research Ethics Board to discuss your experience in the research study.
Study Title: Social Perspectives on Tuberculosis and Immigration  
(Stage 2&3: Clinical Observation and Interviews)

Principal Investigator: Dr. Jane Batt, MD PhD, Medical Director of Tuberculosis Program,  
St. Michael’s Hospital, (416) 864-5431

Co-Investigator: Martyna A. Janjua, MA, Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto,  

Translators: Michelle X. Xin (Mandarin/Cantonese) ; Jing Zhao  
(Mandarin/Cantonese) ; Bhoomika Piplani (Hindi)

Statement of Consent
The research study has been explained to me, and my questions have been answered to my  
satisfaction. I have been informed of the alternatives to participation in this study. I have the  
right not to participate and the right to withdraw without affecting the quality of medical care at  
St. Michael’s Hospital for me and for other members of my family. As well, the potential harms  
and benefits (if any) of participating in this research study have been explained to me.

I have been told that I have not waived my legal rights nor released the investigators, sponsors,  
or involved institutions from their legal and professional responsibilities. I know that I may ask  
now, or in the future, any questions I have about the study. I have been told that records relating  
to me and my care will be kept confidential and that no information will be disclosed without my  
permission unless required by law. I have been given sufficient time to read the above  
information.

I consent to participate. I have been told I will be given a signed copy of this consent form.

_________ Study Participant’s Name _________ Signature _________ Date

My signature means that I have explained the study to the participant named above. I have  
answered all questions. I attest that consent was given voluntarily.

_________ Name of person obtaining consent _________ Signature _________ Date

(continue if applicable)
Was the participant assisted during the consent process? □ YES □ NO  
If YES, please check the relevant box and complete the signature space below:
□ Consent obtained with an interpreter present

Social Perspectives on TB and Immigration (Stage 2&3), Version Date Mar. 16, 2015

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The person signing below acted as an interpreter for the participant during the consent process and attests that the study as set out in this form was accurately interpreted and the participant has had any questions answered. I am not involved in the research study. I agree to keep confidential all personal information of the potential participant.

Name of Interpreter ___________________ Signature ___________________ Date ___________________

Relationship to Participant ___________________ Language ___________________ Contact Information ___________________

☐ Consent obtained with an interpreter via telephone
As far as I know, the contents of this consent form were translated and discussed with the help of Language Line, an interpreter service used by the St. Michael’s Hospital TB Clinic. As a witness, I attest that I was present during the consent process and, to the best of my knowledge, the interpreter explained the study as set out in this form. Any questions posed by the participant have been answered. As a witness, I attest that the participant apparently understood all the information provided and that the consent was freely given by the participant.

Name of Interpreter ___________________ Language ___________________ Date & Time ___________________

Name of Witness ___________________ Signature ___________________ Relationship to Participant ___________________

☐ Oral consent / Assent
I, _____________________________ was present when ____________________________ read this form to (or discussed the contents of this form with) the participant. I confirm that the participant gave his or her verbal assent to take part in this study.

Name of person who obtained assent ___________________ Position of person who obtained assent ___________________ Signature of person who obtained assent ___________________

Signature of Witness ___________________ Date ___________________ Relationship to Participant ___________________
Appendix D  “The Consequences of Conducting Critical Qualitative Research Under Neoliberal Institutional Policies"

**Title:** The Consequences of Conducting Critical Qualitative Research Under Neoliberal Institutional Policies

**Citation:** Janjua, M.A., Gastaldo, D., & Bender, A. (2016, May). *The Consequences of Conducting Critical Qualitative Research Under Neoliberal Institutional Policies*. Presented at the 12th International Congress of Qualitative Inquiry, University of Illinois at Urbana-Champaign, U.S.A.

**Abstract:**

As public health institutions in Canada, hospitals operate under a neoliberal government agenda. Along with their mission to provide evidence-based patient care, hospitals have also long been sites of health research. Many large teaching hospitals in fact house fully resourced research institutes, structured according to positivist assumptions about research. This creates particular challenges for conducting studies that ascribe to alternative traditions which fall outside the positivist paradigm. The focus of this paper is to discuss the challenges of conducting critical qualitative health research in such a setting. We present our own account of navigating through the system to undertake a critical social study with marginalized immigrant populations. We discuss some of the practical and methodological consequences that these institutional policies have had at various stages (ethics approval, participant recruitment, data collection and data quality) of our study, and provide some practical strategies for overcoming these barriers in future research.

**Keywords:** methodology, recruitment, immigrant health research

Neoliberalization of healthcare has caused a shift in ideology that underpins the ways in which we as a society think about health, and has impacted the types of research that is considered legitimate and most valuable. Hospitals and their research institutes have increasingly focused on positivist research, prioritizing Clinical Trials and other quantitative studies predominantly in the biomedical sciences. This creates particular challenges for conducting studies that ascribe to alternative traditions, which fall outside the positivist paradigm as they are challenged on ontological, epistemological and methodological grounds. Before continuing further, I would like to introduce the concepts of positivism and Neoliberalism in the context of health research and briefly discuss how they relate to each other, as well as outline the implications they have for social health research.
Positivism in Health Research: Biomedicine vs. Social Health Research

In the Canadian context, interdisciplinary health research has recently become more common as it is believed to produce “better” solutions to common health problems. Interdisciplinarity presumes that groups of researchers representing a plurality of approaches will somehow come together and all equally and harmoniously contribute to a study. Such a belief is rather naïve as it ignores the set structural forces and established social order of dominant biomedical discourses; any attempts to contribute to a research design based on rationalities from other disciplines are met with resistance.

To better understand the structures and interactions in such a setting it is useful to introduce Knorr-Cetina’s (1999) concept of “epistemic cultures” which refers to the “different scientific communities [such as] basic scientists, clinician scientists, epidemiologists, social scientists” etc., who ascribe to different scientific cultural practices, rationalities and ontologies (Albert et al., 2008, p. 2522). Framing various groups of scientists, and forms of knowledge that they produce, as culturally distinct allows us to identify and analyze the source of tensions that arise between the various groups. These tensions, or the “clash between epistemic cultures” as Albert et al. (2008) put it, exist because “different disciplines…discursively constitute the interdisciplinary health research field” (Albert & Paradis, 2014, pp. 363) in various ways, and the ways in which scientists from different epistemic cultures can interact with each other are shaped by a structured network of power relations that operate along these cultural lines (Albert et al., 2008, pp. 2522).

The dominance of positivism in health science carries tremendous implications for interdisciplinary research overall, and social health research specifically. First, social health scientists’ “legitimacy and scientific authority are not recognized by the dominant [biomedical] epistemic [culture] in the health research field” (Albert & Paradis, 2014, p.375), and second, the value and quality of their work is interpreted and judged through a positivist lens. As a result, in order to be successful, social scientists must adapt to, and function by, these dominant rationalities often at the expense of research quality as judged by their own disciplinary standards of excellence.

Neoliberalisation of Science

Over the past few decades, the very nature of research has evolved from science as a pursuit of knowledge and truth, to science as an economic enterprise (Albert & Paradis, 2014, pp. 362). This has certainly been
true of the health sciences where there has been an increase of funding initiatives reflecting this agenda. While the Canadian Institutes of Health Research (CIHR), one of the national research funding agencies, has committed to support interdisciplinary health research, this commitment has not been reflected with equal and diverse representation of disciplines on governing committees. Albert and Paradis (2014) report that biomedical sciences had the highest representation on committees that govern funding and leadership for health research in Canada (with approximately 60%), whereas social sciences and humanities researchers combined had, at most, only 5% of representation (p. 369). The exclusion of social scientists and humanities scholars with expertise in health from national governing, funding, and leadership committees is a manifestation of the clash of epistemic cultures which consequently result in the underfunding of social health research in Canada. Furthermore, underrepresentation of social scientists leads to the reproduction of, and support for, policies informed by positivist rationalities.

In a society functioning under the auspices of an open market system, access to funding is essential for the success of research projects as well as the careers of researchers themselves. In essence, academic research has become commercialized (Albert & Paradis, 2014, pp. 362); many institutions and departments regard the value of funding awarded to a researcher, rather than the quality of their work, as criteria indicative of their success. At a time when economic value of research has become synonymous with scientific merit, social scientists, as outsiders in the health field, are increasingly disparaged. As a result, the shift in focus from knowledge production to profitability further contributes to the devaluation of social sciences within the health domain.

Theoretical Framework

Our own interpretation of this issue is informed by poststructuralist theory and the work of Michel Foucault. We regard the biomedical epistemic culture as a dominant discourse, or, as per Foucault, a system of thoughts, actions, practices and beliefs, which “construct knowledge about a particular topic or practice” (Hall, 1997, pg. 4). Each discourse has underlying rules or “regimes of truth” (Foucault 2010) that structure and legitimize who has the authority to speak the truth (or produce knowledge), and who does not. Discourses both produce and transmit power (Foucault, 1998); the knowledge imbued in discourses is taken up by various social actors and reproduced through language and practices. Multiple discourses simultaneously operate and intersect at the site of social phenomena, where they form a relation of power that leads to “a battle among discourses and through discourses” (Foucault, 1982, p. x). This battle is a combat over the legitimacy and authority to define a phenomenon. Thus by adopting accepted forms of knowledge, discourses can be strategically taken up by various actors as a way to
negotiate power. Viewing biomedical epistemic culture as a dominant discourse on health allows us to problematize the power formation and the social order that it gives rise to in the realm of health sciences. Thus the tensions over authority and legitimacy of whose “science” is true lies at the heart of the power relations between social and biomedical health researchers.

Session Goals

The goal for this session is to provide a platform for a discussion of the barriers and consequences that arise from neoliberal ideologies and dominant positivist discourses for qualitative health researchers within varying academic and health system contexts. In my talk today, I will present the challenges that we have faced in trying to carry out a study at a hospital and a public health department. The experiences I present to you come from my doctoral study, and while this paper is coauthored by two members of my supervisory committee. I will be speaking from my positionality as a student and junior researcher; I hope to give you a glimpse into some of the most difficult aspects of this journey as we tirelessly, and admittedly sometimes with little hope, pushed to operationalize this study.

Overview

I present you with a brief overview to guide you through this talk. To begin, I will introduce and contextualize the study to you. Next, I will discuss the challenges that we have faced during the course of the study, and provide you with five specific examples. Lastly, I will discuss the effects these have had on myself, in this particular case as a PhD student, as well as my supervisory committee, revealing the dominant discourse that intersects and shapes research in North American Health Care institutions.

The Study: “Social Perspectives on Tuberculosis (TB) and Immigration”

The information about the study serves as a backdrop to today’s presentation. This study, as I mentioned, is my PhD research titled “Social Perspectives on Tuberculosis and Immigration”. The purpose of the study is to explore the effects of Tuberculosis screening and medical surveillance during the process of immigration and settlement on newcomers to Toronto, Canada. Methodologically and conceptually, our understanding of this topic is guided by poststructural theory; we employ Foucauldian Discourse Analysis and utilize the Social Determinants of Health framework which permit us to better understand the ways in
which new immigrants engage with power relations at various stages of the migratory journey, and what
effects this has for their overall health and wellbeing.

Methods & Data Generation

The data for this study were generated through observations and interviews. Data collection took place
over 10 months from July 2015 until May 2016. I 1) conducted observations of a hospital-based
outpatient TB clinic, 2) observed and audio recorded TB clinic appointments for immigration applicants
undergoing medical surveillance as part of their immigration requirements; 3) and interviewed
immigration applicants who have completed, or almost completed, their immigration medical
surveillance. In sum, I have a notebook full of observation notes, I’ve recorded 14 clinic appointments
and conducted 15 interviews with 13 participants. In total, 16 individuals took part in the study. I am
currently in the process of transcribing and analyzing data.

Challenges: Research Ethics Board (REB) Approval

Because this study is a doctoral thesis where participant recruitment and part of data collection took place
in a clinical setting, we had to obtain ethics approval from 3 separate institutions – a hospital, the
University of Toronto (or UofT), and a public health department. The first approval process through the
hospital took 6 months; the second 1 month, and the third, through the public health department, took 4
months. The majority of challenges faced during this process were a result of having to simultaneously
adhere to somewhat conflicting policies of 3 separate Research Ethics Boards (or REBs), and trying to
negotiate my way through these unknown institutional settings and spaces.

REB vs. REB vs. REB

As I suspect you already know, the function of an REB is to ensure that “proposed studies with human
participants…conform to internationally and locally accepted ethical guidelines, monitor studies once
they have begun and, where relevant, take part in follow-up action and surveillance after the end of the
research” (WHO, 2009, p. 11). Furthermore, the WHO states that “the main responsibility of a research
ethics committee is to protect potential participants in the research” (WHO, 2009, p. 11). One of the ways
in which this is accomplished is to ensure that prospective researchers have adequate training and experience in both research methodologies as well as ethical conduct.

Example 1: Researcher Qualifications

In Canada, all research institutions follow the Tri-council Policy Statement for the Ethical Conduct for Research Involving Humans, and the training for all researchers is standardized. While this may be true, our experience shows that the implementation of these policies varies depending on the institutional setting. At the University of Toronto, graduate students and their supervisors are not required to undertake additional specialized ethics training as part of the ethics review process; as research faculty and professors they are already adhering to these guidelines. Thesis supervisors, as well as students’ supervisory committees, are primarily responsible for ensuring that their students are adequately prepared to conduct ethically sound research. The supervisors’ credentials, faculty appointments, training, as well as past experience as both researchers and student supervisors are accepted by the REB as evidence of their ability to provide student guidance in this area. If the need arises, however, they are encouraged to consult with the REB to “ensure the development of ethically sound research protocols…in accordance with federal, provincial and institutional requirements and best practices” (UofT REB Website: accessed May 2, 2016). As such, neither myself, as the student researcher and principal investigator, nor any of my committee had to complete ethics training prior to obtaining ethics approval from UofT. In contrast, however, both the hospital and public health REBs mandated additional Tri-council online training “for anyone conducting research activities” (Hospital REB Submission Checklist, 2015), including myself as well as my supervisor. The training course is an introductory online tutorial which requires 4 hours to complete.

After providing an explanation of why the Student’s Supervisor should be exempted from having to complete this introductory training (including previous experience as an REB committee member, continually teaching research ethics content at the university, experience supervising over 20 PhD students, director of the Centre for Critical Qualitative Health Research at the University of Toronto, a record of several funded research projects), the Hospital REB granted an exemption for my supervisor from having to complete this tutorial; the Public Health REB, however, did not. In their response, the reviewers stated:

Thank you for the thorough explanation of Dr. Gastaldo’s experience and credentials. The [Public Health Unit] REB does not conduct individualised assessments related to the requirement that all Project Principal Investigators provide a certificate of completion of the TCPS2 tutorial. This
Example 2: Assessment of Risk

Our second example highlights similar inconsistencies around assessment of risk. The assessment of risk in research involving human participants determines the REB review process itself: research where risk is low or minimal may be accepted for delegated / expedited review (which involves either one member or a subcommittee), whereas research that poses a moderate or high risk to the participants must undergo full ethics review involving the full ethics committee. The concept of “risk” is not universal and may differ depending on the dominant discourse under which the specific REB is operating.

Both the Hospital and University REB follow the Tri-Council Policy Statement on risk, and categorize a study as posing **Minimal risk** if “the probability and magnitude of possible harms…is no greater than those encountered by participants in aspects of everyday life that relate to the research” (TCPS2, 2014). The Hospital REB, however, provided no further instructions for, or explanation of risk evaluation; under positivist research paradigms, risk is relative compared to randomized control trials (which is considered the gold standard) and invasive research procedures or interventions. Based on this rationality, our critical social study was categorized as posing “minimal risk” and was accepted for delegated review.

In contrast, the University REB evaluates risk based on a combination of both group vulnerability and research risk. Group vulnerability considers “any pre-existing vulnerabilities associated with proposed participant groups, for example those relating to pre-existing physiological or health conditions, cognitive or emotional factors, and socio-economic or legal status” (UofT REB Website: accessed May 2, 2016). Research risk refers to

> the probability and magnitude of harms participants may experience as a result of the proposed methods to be used and types of data to be collected, for example relating to physiological or health issues such as clinical diagnoses or side effects, cognitive or emotional factors such as stress or anxiety during data collection, and socio-economic or legal ramifications such as stigma, loss of employment, deportation, or criminal investigation. (UofT REB Website: accessed May 2, 2016)

Under these criteria, both group vulnerability and research risk in our study are medium or high. Had our study required REB approval from the university first, according to the Risk Matrix we would have had to undergo full ethics review.
Example 3: Methodological Requirements

The University REB requires students and researchers to obtain ethics approval from institutions outside the university where the study may take place prior to filing an ethics application at UofT. The process for obtaining REB approval from the university itself, however, is centralized. Once approved, the governance of research procedures, including methodology, becomes the responsibility of the student and her advisory committee. In contrast, the ethics approval process both at the hospital and public health department require additional involvement of other departments within their respective institutions. Assessment by, and clearance from these departments regarding research methods is necessary in order for the REBs to issue approval.

In our experience, while seeking to obtain REB approval at the hospital, I was referred to the Office of Research Administration, the Privacy Office, and the IT Department to set up a contract and account for paying interpreters, clarify the requirements for an appropriate audio recording device, and to install hospital software on my personal research device, respectively. Again, all these requirements had to be met before the REB would issue approval for the study to begin.

Navigating between the hospital REB and the Privacy Office proved to be most challenging as both these departments had different interpretations on what type of audio recording device is acceptable, and what procedures I needed to follow to ensure that the data I collected via this method was kept secure. While the REB approved the proposed recording device and informally issued an approval for the study in email communication, the Privacy Office rejected the use of the proposed audio recording device and denied commencement of the study after REB approval was already granted. The privacy office recommended that I, a graduate student without research funding, must either arrange for the hospital IT department to install encryption software on my personal device at a cost of $100 Canadian dollars, OR purchase an encrypted audio recording device, for which cost exceeds $700 Canadian dollars.

This was troubling for several reasons. First, these requirements are a manifestation of the dominant biomedical discourses operating at this institution. These policies are crafted within an epistemic culture where funding is readily available from other economic sectors such as pharma or even the government. These dominant discourses silence and ignore the realities that social health researchers, particularly students, are underfunded and may not necessarily have the resources to meet some of these requirements. Furthermore, these mandates were communicated directly to me, yet there was no communication about this issue between the departments. As a junior researcher, and university graduate student, receiving such
conflicting messages about what is and is not acceptable was confusing and troubling, and attributed to delays in the study. From the onset it became clear that it would be challenging to conduct a study in a setting where different departments within the same institution could not agree on which policies and procedures to follow.

Example 4: Methodological Requirements

Our methodological decisions were also challenged by the public health department REB. Study information submitted for ethics review was consistent for all three REBs. The title and purpose of the study remained the same and conveyed the intersection of migration and TB medical surveillance as the area of interest. While the hospital and university REBs did not see a problem with the interview guide, the public health department did. In our communication, we were directed to remove the first three interview questions asking about the immigration journey and the context of their daily lives of participants pre- and post-migration. Under the heading “required modifications”, the reviewer wrote:

The focus of the study is on how people experience medical surveillance for TB. The interview questions should be directly related to the focus of the study. The first three questions could elicit information that is not necessarily related to how people experience TB medical surveillance. Answering Qs 2 and 3 could contribute to participant psychological distress. (Public Health Unit REB, Jan. 29, 2016)

Here are the questions the reviewer was referring to:

Q2. Tell me about your immigration journey.

Q3. Describe what your life was like back home. What is life like here for you?

I hope it is apparent that the questions which ask participants to describe the conditions of their lives before, during, and after migration are relevant to the research question and the goal of the study. While the interview guide was developed with the help of my research committee, and approved by these 4 experts, as well as 2 other REBs, this fact seemed to have little impact on the assessment process at this stage. Returning to our points presented earlier, these examples are just some of the ways that demonstrate the effects of qualitative research being evaluated and interpreted through a positivist lens. The REB process no longer centered around ethical conduct in its assessment, but rather shifted focus onto the procedural elements of the study. This not only created additional layers of bureaucracy for the researcher resulting in a need to negotiate between various departments, (a particularly challenging feat
for an outsider to the institution), but also formulated a rationale for ethics boards to interfere in methodological decisions.

Example 5: Methodological Requirements – Recruitment

The last example I would like to present speaks to the involvement of the REBs in defining the recruitment process, and its subsequent implications for the study. As I indicated earlier, both the subject of our study and the vulnerability of the population increased the potential risk of harm to research participants. With this in mind, we carefully crafted the recruitment strategy, balancing both participant safety and pragmatism. Several publications document the most effective and ethically acceptable methods of recruiting vulnerable populations for qualitative health research, which we cited as our rationale for the proposed recruitment procedures. The REBs, however, rejected our plans, insisting that the methods we proposed were not in line with recruitment practices deemed acceptable by their institutions. We knew that the REB-mandated procedures in this case, which were informed by biomedical discourses and positivist logic, were incompatible with the research methodology and thus not appropriate for a cross-cultural study involving vulnerable populations. We anticipated that implementing these procedures would threaten the very success of the study itself by posing a barrier to participant recruitment. Our views, however, represented competing discourses and, as social health researchers working in a realm where biomedical epistemic culture dominates, we had no choice but to comply.

Until an amendment was permitted 3 months after the study began, the hospital REB-mandated recruitment procedures were as follows: The administrative staff provided prospective participants with a 6 page information and consent package about the study at check-in. This information was to be reviewed by the patients on their own prior to their clinic appointments. During this time, patients were sent for x-rays and may have had to undergo further testing (a process lasting between 30 mins and 2 hours). Finally, as they were ushered into the exam room through the clinic, a nurse would ask: “Did you read the information about the study? Are you interested?” The typical answer would be “No” at which point the conversation about the study was finished and the nurse would turn their attention to the reason for the clinic visit. Given that many of these prospective participants didn’t speak English and were already under a lot of stress, the resulting recruitment rate using this method of 26% was not at all surprising.

After an amendment to the recruitment procedures was granted, I was finally allowed to approach prospective participants myself. I waited until they returned from the imaging department and asked to speak with them in private. After introducing the study, if the patient was interested in hearing more, I explained the procedures and obtained consent personally. These conversations took place in an exam
room, usually with access to interpretation services. Following this method, the recruitment rate increased to 55%.

We had a similar experience with the public health REB who dictated that only passive recruitment was allowed by mailing out flyers to prospective participants; our proposal to have a public health staff member reach out to clients to introduce the study was rejected. In the end, a total of 53 flyers were mailed out to public health clients; only two individuals responded, resulting in a recruitment rate of 4%.

Discussion

So what were the effects of all this? What can we take away from our experience?

Effect 1: Confusion Over REB Jurisdiction

The first challenge we presented highlights the difficulty of undergoing ethics approval requiring multiple REB involvement. As a student, I am bound to comply with the University policy and procedures first and foremost, which state that ethics approval must be obtained from other research institutions in its research network prior to submitting an application to the university REB. As such, the responsibility for assuring the ethical conduct of a graduate research study falls onto another REB (or in our case two other REBs). While all REBs adhere to the same national document: the ‘Tri-council Policy Statement: Ethical Conduct for Research Involving Humans’ (2014), the discourses that dominate practices and procedures within each institution vary, resulting in different interpretations of what constitutes ethical conduct. If each institution functions according to different rationalities and the multiple REB involvement results conflicting interpretations of what delineates ethical conduct, whose criteria are researchers to follow, and ultimately, who is responsible for overseeing the study?

Effect 2: Time Delays

The positivist interpretations and operationalization of ethics discourses by the hospital and public health REBs imposed restrictions on how and where I could conduct my doctoral research in ways that interfered with the progress of the study. While they were intended to protect participants, these decisions posed a serious threat to the very success of the study, not only jeopardizing the research project as a scientific
undertaking, causing us to revise the study objectives several times, but also threatening my ability to
complete my academic program and obtain my degree in a timely fashion. The initial REB approval
process lasted 7 months (6 months of “delegated” review at the hospital, and 1 month of administrative
review at the university). These 7 months were spent making countless phone calls, writing multiple
emails to numerous individuals and fulfilling other requirements, and eventually required intervention
from my supervisory committee to facilitate the process. Ethics approval at the public health department
lasted 4 months and progressed in a similar fashion.

Additional delays occurred during the recruitment and data collection stage as the REB-mandated
procedures first required adequate time to fail prior to requesting an amendment. These delays carried
serious financial consequences, and resulted in incurred stress on myself, my family and my supervisory
committee.

Effect 3: Helplessness

The added layers of bureaucracy typical of neoliberal institutions carry their own set of consequences.
The mandatory completion of the training module mentioned earlier was redundant and difficult to
complete by faculty who were already stretched for time. It also further contributed to time delays.

There was another policy that appeared to only serve a bureaucratic purpose. I have not yet mentioned it,
but find it necessary to do so at this point as its effects were significant; it was the requirement to appoint
a hospital employee as the Principal Investigator (or PI) on any research conducted at the hospital. As a
student researcher, while I was technically the PI on my own dissertation research, I had to relinquish
that role to another individual who did not take part in the theoretical, methodological or analytical
development of the study. While I received ample support from the PI in the form of access to the study
site and facilitation of the REB process, the restrictive hospital REB policies stripped me of control over
my own study. For instance, in an effort to expedite any amendments submitted to the REB, the PI had to
make revisions to the “study protocol” (which was originally my PhD Thesis Proposal). While this was
logistically the quickest way to ensure that appropriate changes could be implemented and was greatly
appreciated, from my location as a student, sitting back and watching another individual make revisions
that may not be fully methodologically congruent with the study felt a bit like my PhD thesis was taken
hostage.

As researchers, we attempt to consider all possible outcomes and speculate on the implications of our
methodological and theoretical choices. While there is no doubt that we can oversee things, (which is the
very reason why the peer review process exists), chances are that we probably know what will help to make our study successful, and what will likely cause it to fail. It can be incredibly distressing when a governing body rejects what you’ve thoughtfully concluded to be your best chance of success and, instead of supporting and working with you, dictates that you must follow their directive instead, particularly if you know it will likely end in failure. As a result, you are stuck and helplessly bound by institutional policies if you intend on conducting the study at all.

During our communication with the REBs throughout the ethics review process, I often had the feeling that THEY JUST DON’T GET IT!!! It was frustrating to feel that they didn’t understand the study and yet had complete control over methodological decisions.

In the clinic, I was overcome with similar feelings of despair and hopelessness. I had no choice but to sit back and watch as the few potential participants who entered the clinic were approached for recruitment by a group of individuals who were not familiar with, nor invested in, the study. I had to wait for 3 months to pass with little progress – 3 months for which I was paying tuition – before I could go back to the REB and plead with them to let me try it my way, because their way was not effective. Finally, after my case was supported by the hospital “PI”, the REB reluctantly allowed me to recruit the way I had originally proposed, in a way that was both ethical and methodologically compatible with the study.

In addition to this example speaking to the lack of control over procedures and methodology, it highlights the dominant discourse and rationality under which biomedical research functions with respect to support. It is typical in this setting for teams of clinical staff to be involved in the recruitment process of their patients for other clinical researchers. However, what fails to be acknowledged is the social location and access to power that an outsider to the institution, especially a student and junior researcher, has in the same context; an outsider (both to the institution and to the epistemic culture) will not have the same level of support as an ‘insider’ researcher would, which has the potential to significantly undermine the success of a study.

**Conclusions**

The ways in which discourses on ethics are taken up and operationalized in the biomedical field carry the implication that the researcher herself is unable to assess what dictates ethical behaviour, and if her conduct during recruitment deviates from what is allowed, she will be acting unethically. Any changes to REB approved procedures cannot be determined by the researcher alone; even if their effects are detrimental to the study, she is not trusted to possess the ability to act ethically on her own and requires
institutional governance. In essence, the researcher is denied the right to self-determination. As social research requires methodological flexibility and a certain amount of freedom to creatively overcome obstacles, which naturally arise during human interaction, strict policies stifle this creativity and thus the ability to progress through the research process. In closing, conducting critical social health research under neoliberal institutional policies in our experience has been challenging at multiple steps of the process, and we have found that it carries real material, as well as less tangible yet equally important consequences for the researchers involved.

Acknowledgements

I would like to acknowledge the Social Sciences and Humanities Research Council of Canada for providing partial graduate funding.

References


Seeking Participants

Research is now being undertaken at the University of Toronto

What’s it like being screened for tuberculosis as part of your immigration to Canada?

**Who:** NEW IMMIGRANTS WHO RECENTLY COMPLETED TB MEDICAL SURVEILLANCE THROUGH TORONTO PUBLIC HEALTH

**What:** A 60-90 MINUTE INTERVIEW ABOUT YOUR EXPERIENCE WITH IMMIGRATION AND TUBERCULOSIS TESTING. YOU MAY BE ASKED TO TAKE PART IN A SECOND INTERVIEW.

**Where:** INTERVIEWS WILL BE HELD AT A LOCATION OF YOUR CHOICE.

To participate you must:

* Be 18-60 years old
* Have applied for immigration to Canada as a Permanent Resident
* Be willing to talk about your experience

**Compensation:** IN APPRECIATION OF YOUR TIME YOU WILL RECEIVE $15 CASH PER INTERVIEW. IF TRAVEL TO THE INTERVIEW LOCATION IS NECESSARY, THE COST OF PUBLIC TRANSIT WILL BE REIMBURSED (TTC TOKENS).

**Note:** Your decision to participate in this study is voluntary — it will **NOT** in any way affect your immigration process or your access to health care now or in the future.

For more information on the project, including how to participate, contact Martyna Janjua (PhD Candidate) of Dalla Lana School of Public Health at the University of Toronto

Phone or Text: [xxx] xxx-xxxx Email: martyna.janjua@mail.utoronto.ca

All enquiries will be treated privately and confidentially

DALLA LANA SCHOOL OF PUBLIC HEALTH, UNIVERSITY OF TORONTO, 155 COLLEGE ST., TORONTO, ONTARIO, M5T 3M7
Appendix F  Public Health Recruitment: Participant Consent Form

Consent to Participate in a Research Study
Study Title: Social Perspectives on Tuberculosis and Immigration

Principal Investigator / Researcher
Martyna A. Janjua, PhD Candidate, Dalla Lana School of Public Health, University of Toronto
Contact: Tel. (xxx) xxx-xxxx (A temporary research telephone number will be set up for the study), email: martyna.janjua@mail.utoronto.ca

PhD Supervisor
Denise Gastaldo PhD, Associate Professor, Bloomberg Faculty of Nursing and Dalla Lana School of Public Health, University of Toronto
Contact: Tel. (416) 978-4953, email: denise.gastaldo@utoronto.ca

Introduction
- Please read this form carefully before agreeing to take part in this study.
- If you have any questions, please ask the Principal Investigator or her PhD Supervisor.
- You should not sign this form until you are sure you understand the information.
- You DO NOT have to participate in this study if you don’t want to. You can agree to be in this study now and change your mind later.

Study Funder
- This study is funded by the Social Science and Humanities Research Council (SSHRC) Joseph-Armand Bombardier Canada Graduate Doctoral Scholarship (Award No. 767-2009-1190).

What is this study about?
- In this study we want to understand how being tested for tuberculosis (TB) during immigration affects you personally as a newcomer. Your experience is unique and valuable.
- What you tell us can help doctors and others working with new immigrants understand how to better help newcomers after they move to Canada. Doctors and researchers know a lot about TB, but little is known about the perspectives or experiences of newcomers who have to be tested for TB after coming to Canada.
- This research is part of a doctoral (PhD) thesis in Public Health at the University of Toronto. It is NOT organized by Toronto Public Health or Citizenship and Immigration Canada (CIC).

Why am I being asked to take part in this research study?
- You are asked to be in this study because you had to complete TB Medical Surveillance through Toronto Public Health as part of your immigration to Canada.
- Participants in this study are immigrants from anywhere in the world.
- If you are in Canada as a refugee, temporary migrant worker or international student, or are not seeking to stay in Canada permanently, you DO NOT qualify for this study.
What will I be asked to do?
- You are being asked to participate in the interview part of the study. Approximately twelve (12) people will be enrolled in this part of the study.
- You will be asked to meet with the researcher for an interview lasting about 60-90 minutes. You may be asked to meet for a second interview a week later.
- These meetings may take place in a private office at the University of Toronto or another quiet place where you feel comfortable talking about your experiences with TB and immigration. Both you and the researcher will agree on the exact time and place to meet for interviews.
- If you participate, you will be asked to fill out a short questionnaire before the first interview asking for information like your age, where you come from, some information about your immigration and your Immigrant Medical Examination (IME).
- During the interviews, the researcher will ask you questions about TB and immigration to better understand your experience with TB testing as a newcomer. Some questions you will be asked are:
  o How and why did you decide to come to Canada?
  o What you know about TB?
  o How and where were you tested for TB?
- These interviews will be audio recorded. If you do not wish to have your answers recorded, please tell me - I will not record them; I will write down your responses during the interview instead.
- If you do not speak English, an interpreter will come to the interview to act as a translator.

What are the risks or discomforts?
- The biggest risk to you in this study is the unintentional release of information from your study records. The researcher will protect your records and keep confidential any information collected, including your name, address and telephone number. The chance that this information will accidentally be given to someone else is small.
- Talking about your experience of TB may make you uncomfortable or upset, but it may help some people feel better. This will be different for everyone.
- This study may also include other risks that are unknown at this time.
- If for any reason you feel distressed as a result of your participation in this study and you feel that you need to talk to someone, you may contact the Distress Centre (416-408-HELP (4357)) or Gernstein Centre (416-929-5200). These are confidential local programs designed to help address any mental and physical health concerns and provide emotional and physical support by telephone.

What are the benefits to me?
- You are not expected to get any benefit from this study.
- Information learned through this study may help provide future immigrants with better care during TB testing or access to other services.
Will my information be kept private?
- Your health or personal information collected during this study will NOT be used in a way that could identify you. We will do everything we can to make sure this data is kept private.
- Sometimes, by law, we may have to release your information with your name (in cases if we see evidence of self-harm, harm to others or child abuse), so we cannot guarantee absolute privacy. However, we will make every legal effort to make sure that your information is kept private and confidential.
- The de-identified information we collect about you will be used for a doctoral thesis, published research papers and conference presentations, and may be presented at seminars or other public forums, or may be used for teaching purposes. We will NOT use your real name in any written reports – we will only refer to you by a pseudonym (a fake name) that you choose.
- Research records will be kept secure in a locked file. All electronic information will be coded and secured using a password-protected file.
- Only the researcher has access to audio recordings. Sometimes either the researcher’s supervisor, or in cases where interviews are conducted in a language other than English, an interpreter may hear parts of the audio recordings.
- Anonymized and de-identified research records will be stored for five years after the study is completed. The researcher will store these records securely as password-protected files.
- The information collected for this study may be seen by the Research Ethics Boards at Toronto Public Health and at the University of Toronto for monitoring purposes. A representative of the Research Ethics Board may contact you to ask questions about your experience with the recruitment and consent process, or about your experience in this study, to make sure that the researcher followed all procedures correctly.

Will I be told about the results of this study?
- No, you will not be directly informed of the study results. If you wish to have a summary of the results of this study you may contact the researcher or her supervisor once the researcher’s doctoral thesis is complete, in September 2016.

Will I be paid to be in this study?
- You will be paid $15 for each interview (for a total up to $30). If you have to travel to the interview location you will be given two Toronto Transit Commission (TTC) tokens to cover the cost of public transportation for each interview.

Do I have to participate?
- Your participation in any research study is voluntary. If you choose NOT to participate, it will NOT affect your access to any current or future medical care. It will also NOT affect your immigration status with CIC in any way.

What if I change my mind?
- If you participate in the study but change your mind later, you can stop at ANY TIME, for whatever reason. If you no longer want to participate you do NOT have to say why.
There is no penalty or loss of benefits to you or your family for not taking part or for stopping your participation.
- If you change your mind and no longer want to participate, you can ask for your interview to be excluded from the study; the audio recording of your interview and any transcripts of the interview will be erased. You have up to a week from the day of the interview to request for the withdrawal of your interview data.
- You may be contacted by the researcher during the analysis stage for clarification of interview data, if needed.

What if I have questions?
- If you have any questions about the study, please contact the Researcher or her Supervisor.
- If you have any questions about your rights as a research participant, you may contact the Research Ethics Board (REB) at the University of Toronto at (416) 946-3273 (ethics.review@utoronto.ca). The REB is a group of people who oversee the ethical conduct of research studies. They are not part of the study team. Everything that you discuss with them will be kept confidential.

Conflict of Interest
- The Researcher and her PhD Supervisor declare that they have no conflicts of interest.
Study Title: Social Perspectives on Tuberculosis and Immigration

**Principal Investigator / Researcher**
Martyna A. Janjua, PhD Candidate, Dalla Lana School of Public Health, University of Toronto  
Contact: Tel. (xxx) xxx-xxxx (A temporary research telephone number will be set up for the study), email: martyna.janjua@mail.utoronto.ca

**PhD Supervisor**
Denise Gastaldo PhD, Associate Professor, Bloomberg Faculty of Nursing and Dalla Lana School of Public Health, University of Toronto  
Contact: Tel. (416) 978-4953, email: denise.gastaldo@utoronto.ca

**Statement of Consent**
- The research study has been explained to me, and my questions have been answered to my satisfaction. I have been informed of the alternatives to participation in this study.
- I have the right not to participate and the right to withdraw without any consequences for me and for other members of my family.
- The potential harms and benefits of participating in this research study have been explained to me.
- I have been told that I have not waived my legal rights nor released the investigators, sponsors, or involved institutions from their legal and professional responsibilities.
- I know that I may ask now, or in the future, any questions I have about the study. I have been told that information collected about me will be kept confidential and that no information will be disclosed without my permission unless required by law.
- I have been given sufficient time to read the above information.

I consent to participate. I have been told I will be given a signed copy of this consent form.

<table>
<thead>
<tr>
<th>Study Participant’s Name</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

If needed, can the researcher contact you during the analysis stage of the study for clarification of interview data?  
☐ YES  ☐ NO

My signature means that I have explained the study to the participant named above. I have answered all questions. I attest that consent was given voluntarily.

<table>
<thead>
<tr>
<th>Name of person obtaining consent</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>
Was the participant assisted during the consent process? □ YES □ NO
If YES, please check the relevant box and complete the signature space below:

☑ Consent obtained with an interpreter present
The person signing below acted as an interpreter for the participant during the consent process and attests that the study as set out in this form was accurately interpreted and the participant has had any questions answered. I am not involved in the research study. I agree to keep confidential all personal information of the potential participant.

Name of Interpreter ___________________________ Signature ___________________________ Date ___________________________

Relationship to Participant ___________________________ Language ___________________________ Contact Information ___________________________

☑ Consent obtained with an interpreter via telephone
As far as I know, the contents of this consent form were translated and discussed with the help of a professional interpreter service, Access Alliance Language Line. I attest that, to the best of my knowledge, the interpreter explained the study as set out in this form. Any questions posed by the participant have been answered. I attest that the participant apparently understood all the information provided and that the participant freely gave their consent.

Name of Interpreter ___________________________ Language ___________________________ Date & Time ___________________________

Name of Witness ___________________________ Signature ___________________________ Relationship to Participant ___________________________

☐ Oral Consent
I, ___________________________ read this form to (or discussed the contents of this form with) the participant. I confirm that the participant gave his or her verbal consent to take part in this study.

Signature of person who obtained oral consent ___________________________ Date ___________________________

Name of Witness (if present) ___________________________ Signature of Witness ___________________________ Relationship to Participant ___________________________

Consent Form, Toronto Public Health
Social Perspectives on TB and Immigration, Version Date Mar. 9, 2016
Page 6 of 6
Appendix G  Socio-demographic Questionnaire (Public Health Recruitment)

Socio-demographic Questionnaire
Study Title: Social Perspectives on Tuberculosis and Immigration

Principal Investigator / Researcher
Martyna A. Janjua, PhD Candidate, Dalla Lana School of Public Health, University of Toronto

PhD Supervisor
Denise Castaldo PhD, Associate Professor, Bloomberg Faculty of Nursing and Dalla Lana School of Public Health, University of Toronto

For each question, please mark an “x” in the box to choose your answer or write down your answer in the space provided. Please complete both sides of each page. You do not have to answer a question if you do not want to, just please put a star beside the question(s) you do not wish to answer. If you have any questions or concerns, or if you need help with completing this questionnaire, please let the researcher know.

Socio-demographic Information

1. Because of the topic of this research, it is best to keep your identity private. Please choose a name (pseudonym – NOT your real name) that you would like me to call you in this study:

Pseudonym: ____________________________

2. Age: ________________

3. Gender:  □ Female  □ Male  □ Other: ____________________________

4. Country of Birth: ____________________________

5. Country emigrating from: ____________________________

6. Which languages do you speak? ____________________________

7. Are you/do you consider yourself a visible minority in Canada?

   □ Yes  □ No  □ Don’t Know

8. Did you have a job in your home country before coming to Canada? □ Yes  □ No

9. If yes, what was your job? ____________________________

10. Do you work now?  □ Yes  □ No

11. If yes, what do you do? ____________________________

Socio-demographic Questionnaire, Toronto Public Health
Social Perspectives on TB and Immigration, Version Date Mar. 9, 2016
12. Do you receive any form of social assistance or other payments?  □ Yes  □ No

13. If yes, please check all that apply:  □ Ontario Disability Support Program (ODSP)  
□ Ontario Works  □ Employment Insurance (EI)  
□ Worker’s Compensation (WSIB)  □ Other: __________________________

14. What is the highest level of education that you completed?  
□ Did not attend school  □ Primary, completed up to grade _____  
□ Secondary, completed up to grade _____  □ University, completed _____ years  
□ College or Professional School, completed _____ years  □ Post-Graduate School, completed ____ years  □ Other: __________________________

15. Marital Status:  □ Married or living together as married  □ Single  
□ Divorced  □ Widowed  □ Other: __________________________

16. Do you have children?  □ Yes  □ No  How many? __________

17. Are your spouse/children here in Canada with you?  
□ Yes  □ No  □ Some  □ I do not have a spouse or children

18. If yes or some, which ones? __________________________

19. If no or some, which ones are not here? __________________________

20. Do you have other relatives and friends living here in Canada?  □ Yes  □ No

21. If yes, who? __________________________

22. Where do they live? (province and city) __________________________

23. Who do you live with?  □ Alone  □ Family (specify) __________________________  
□ Friend(s)  □ Roommate(s)  □ Shelter/Temporary Housing  
□ Other: __________________________
24. Number of people currently living in your household (including you): __________________

25. What is your personal average income every month?
   ☐ < $1,000  ☐ $1,000 - $2,000  ☐ $2,000-$3,000  ☐ $3,000-$4,000
   ☐ $4,000-$5,000  ☐ $5,000-$6,000  ☐ $6,000-$7,000  ☐ > $7,000

26. If you live with other family members, what is your average family income every month?
   ☐ < $1,000  ☐ $1,000 - $2,000  ☐ $2,000-$3,000  ☐ $3,000-$4,000
   ☐ $4,000-$5,000  ☐ $5,000-$6,000  ☐ $6,000-$7,000  ☐ > $7,000

27. Do you send any money (remittances) back home on a monthly basis? ☐ Yes  ☐ No

28. If yes, how much money on average do you send every month?
   ☐ < $250  ☐ $250 - $500  ☐ $500 - $750  ☐ $750 - $1,000  ☐ > $1,000

**Immigration Information**

29. Date arrived in Canada (mm/yyyy): __________ / __________

30. Applied for immigration in:  ☐ Canada  or  ☐ Other: __________________________

31. Immigration Class:
   ☐ Family as:  ☐ Spouse/Partner  ☐ Child  ☐ Parent/Grandparent

   ☐ Economic as:  ☐ Skilled Worker  ☐ Canadian Experience
                  ☐ Entrepreneur  ☐ Investor  ☐ Live-in Caregiver
                  ☐ Self-Employed  ☐ Provincial/Territorial Nominee

   ☐ Other: __________________________

32. How did you apply?  ☐ Principal Applicant  ☐ Spouse or Dependant
33. Reason for moving to Canada (check as many boxes as needed):

☐ School  ☐ Work  ☐ Reunite with family
☐ Political/economic reasons in my country  ☐ Other: ____________________________

Health-Related Information

34. Before applying for immigration to Canada, were you ever told you have / may have tuberculosis (TB)?  ☐ Yes  ☐ No

35. If yes, when did it happen (what year was this or how old were you?): _______________________

36. If you have been told you had TB, did you ever take medication for it?  ☐ Yes  ☐ No

37. How long was the treatment for? _______________________

38. Where did you have your medical exam as part of immigration application (Immigrant Medical Examination, IME)?

☐ Canada  ☐ Outside Canada: ______________________ (Country)

39. If yes, where was the IME in relation to where you lived?

☐ same city  ☐ another city  ☐ another province  ☐ another country

40. How long did it take to get there? _______________________

41. Were you tested for TB as a result of the IME before coming to Canada?

☐ Yes  ☐ No  ☐ Don’t Know

42. While in your country, did you receive a “Medical Surveillance Handout” or “Medical Surveillance Undertaking” form telling you that you must contact public health authorities in Canada?

☐ Yes  ☐ No  ☐ Don’t Know

43. If yes, who sent or gave you this information?

☐ Visa Officer in country of origin  ☐ Immigration Officer at Airport / Canadian border

☐ Don’t Know / Don’t Remember  ☐ Other: ____________________________
44. Once you came to Canada, who did you contact first about TB?

☐ I didn’t because I didn’t know I had to contact someone

☐ Family Doctor    ☐ Public Health Nurse    ☐ TB Clinic

☐ Don’t Know / Don’t Remember    ☐ Other: ____________________________

45. When did you start Medical Surveillance / testing for TB in Canada?

(mm/yyyy): __________/______________    ☐ Don’t Know / Don’t Remember

46. What was your diagnosis?    ☐ active TB    ☐ latent TB infection (LTBI)    ☐ no TB

☐ Don’t Know/Dون’t Remember    ☐ Other: __________

47. Did you take medication to treat your TB in Canada?    ☐ Yes    ☐ No
Participant ID: ______________________

Socio-demographic Questionnaire: Stage 1 (Observation)
Study Title: Social Perspectives on Tuberculosis and Immigration

Principal Investigator: Dr. Jane Batt, MD PhD, Medical Director of Tuberculosis Program, St. Michael’s Hospital

Co-Investigator: Martyna A. Janjua, MA, Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto

For each question, please mark an “x” in the box to choose your answer or write down your answer in the space provided. Please complete both sides of the questionnaire. You do not have to answer a question if you do not want to, just please put a star beside the question(s) you do not wish to answer. If you have any questions or concerns, or if you need help with completing this questionnaire, please let the student researcher know.

Personal Information

1. What name would you like me to call you in this study (pseudonym)? ______________________

2. Age: _________

3. Country of Birth: ______________________

4. Country emigrating from: ______________________

5. Which languages do you speak? ______________________

6. What is the highest level of education that you completed?
   - Did not attend school
   - Primary, completed up to grade ______
   - Secondary, completed up to grade ______
   - University, completed ______ years
   - College or Professional School, completed ______ years
   - Post-Graduate School, completed _____ years
   - Other: ______________________

7. Marital Status:  
   - Married or living together as married
   - Single
   - Divorced
   - Widowed
   - Other: ______________________

Socio-demographic Questionnaire: Stage 1
Social Perspectives on TB and Immigration, Version Date 13 Nov. 2014
Immigration Information

8. Date arrived in Canada (mm/yyyy): _______ / _______

9. Immigration Class:

- □ Family as: □ Spouse/Partner □ Child □ Parent/Grandparent
- □ Economic as: □ Skilled Worker □ Canadian Experience
  □ Entrepreneur □ Investor □ Live-in Caregiver
  □ Self-Employed □ Provincial/Territorial Nominee

10. How did you apply?

- □ Principal Applicant □ Spouse or Dependant
Participant ID: __________________

Socio-demographic Questionnaire: Stage 2&3 (Observation & Interview)
Study Title: Social Perspectives on Tuberculosis and Immigration

Principal Investigator: Dr. Jane Batt, MD PhD, Medical Director of Tuberculosis Program, St. Michael’s Hospital

Co-Investigator: Martyna A. Janjua, MA, Doctoral Candidate, Dalla Lana School of Public Health, University of Toronto

For each question, please mark an “x” in the box to choose your answer or write down your answer in the space provided. Please complete both sides of each page. You do not have to answer a question if you do not want to, just please **put a star beside the question(s) you do not wish to answer**. If you have any questions or concerns, or if you need help with completing this questionnaire, please let the student researcher know.

**Socio-demographic Information**

1. What name would you like me to call you in this study (pseudonym)? __________________

2. Age: ______

3. Country of Birth: ____________________________

4. Country emigrating from: ______________________

5. Which languages do you speak? __________________________________________________________________

6. Are you/do you consider yourself a visible minority in Canada?  
   □ Yes  □ No  □ Don’t Know

7. Did you have a job in your home country before coming to Canada?  □ Yes  □ No

8. If yes, what was your job? __________________________________________________________________

9. Do you work now?  □ Yes  □ No

10. If yes, what do you do? __________________________________________________________________

11. If no, do you receive any form of social assistance or other payments?  □ Yes  □ No
Participant ID: ______________________

12. If yes, please check all that apply: □ Ontario Disability Support Program (ODSP)
   □ Ontario Works                       □ Employment Insurance (EI)
   □ Worker's Compensation (WSIB) □ Other: ______________________

13. What is the highest level of education that you completed?
   □ Did not attend school               □ Primary, completed up to grade ______
   □ Secondary, completed up to grade ______ □ University, completed ______ years
   □ College or Professional School, completed ______ years
   □ Post-Graduate School, completed ___ years □ Other: ______________________

14. Marital Status: □ Married or living together as married       □ Single
   □ Divorced                        □ Widowed                   □ Other: ______________________

15. Do you have children? □ Yes       How many? ______
       □ No

16. Are your spouse/children here in Canada with you?
   □ Yes       □ No       □ Some       □ I do not have a spouse or children

17. If yes or some, which ones? ____________________________

18. If no or some, which ones are not here? ____________________________

19. Do you have other relatives and friends living here in Canada? □ Yes □ No

20. If yes, who? ____________________________

21. Where do they live? (province and city) ____________________________

22. Who do you live with? □ Alone    □ Family (specify) ____________________________
   □ Friend(s) □ Roommate(s) □ Shelter/Temporary Housing
   □ Other: ____________________________

23. Number of people currently living in your household (including you): __________

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Socio-demographic Questionnaire: Stage 2&3
Social Perspectives on TB and Immigration, Version Date Mar. 16, 2015

Page 2 of 4

359
24. What is your **personal** average income every month?

☐ < $1,000  ☐ $1,000 - $2,000  ☐ $2,000-$3,000  ☐ $3,000-$4,000

☐ $4,000-$5,000  ☐ $5,000-$6,000  ☐ $6,000-$7,000  ☐ > $7,000

25. If you live with other family members, what is your average **family income** every month?

☐ < $1,000  ☐ $1,000 - $2,000  ☐ $2,000-$3,000  ☐ $3,000-$4,000

☐ $4,000-$5,000  ☐ $5,000-$6,000  ☐ $6,000-$7,000  ☐ > $7,000

26. Do you send any money (remittances) back home on a monthly basis?  ☐ Yes  ☐ No

27. If yes, how much money on average do you send every month?

☐ < $250  ☐ $250 - $500  ☐ $500 - $750  ☐ $750 - $1,000  ☐ > $1,000

**Immigration Information**

28. Date arrived in Canada (mm/yyyy): ______ / ________

29. Immigration Class:

☐ Family as:  ☐ Spouse/Partner  ☐ Child  ☐ Parent/Grandparent

☐ Economic as:  ☐ Skilled Worker  ☐ Canadian Experience

☐ Entrepreneur  ☐ Investor  ☐ Live-in Caregiver

☐ Self-Employed  ☐ Provincial/Territorial Nominee

30. How did you apply?  ☐ Principal Applicant  ☐ Spouse or Dependant

31. Reason for moving to Canada (check as many boxes as needed):

☐ School  ☐ Work  ☐ Reunite with family

☐ Political/economic reasons in my country  ☐ Other: ____________________________
Health-Related Information

32. Before applying for immigration to Canada, were you ever told you have / may have tuberculosis (TB)? □ Yes □ No

33. If yes, when did it happen (what year was this or how old were you?): ________________________

34. If you have been told you had TB, did you ever take medication for it? □ Yes □ No

35. How long was the treatment for? ________________________

36. Did you have a medical exam as part of immigration application (Immigrant Medical Examination, IME) before coming to Canada? □ Yes □ No

37. If yes, where was the IME in relation to where you lived?
   □ same city       □ another city       □ another province       □ another country

38. How long did it take to get there? ________________________

39. Were you tested for TB as a result of the IME before coming to Canada?
   □ Yes      □ No      □ Don’t Know

40. While in your country, did you receive a “Medical Surveillance Handout” or “Medical Surveillance Undertaking” form telling you that you must contact public health authorities in Canada?
   □ Yes      □ No      □ Don’t Know

41. If yes, who sent or gave you this information?
   □ Visa Officer in country of origin □ Immigration Officer at Airport / Canadian border
   □ Don’t Know / Don’t Remember □ Other: ________________________

42. Once you came to Canada, who did you contact first about TB?
   □ I didn’t because I didn’t know I had to contact someone
   □ Family Doctor □ Public Health Nurse □ TB Clinic
   □ Don’t Know / Don’t Remember □ Other: ________________________

---

Researcher use only: Recruited for interview? □ Yes □ No
Appendix I  TB Clinic Observation Data Sheet

Observation Data Sheet

Observation #_____  Stage:_____  Pseudonym:________________________

Setting: (Examination room description: colour/placement and number of doors / windows, furniture and arrangement, types and placement of posters, types/placement of medical tools / equipment, decorative pieces, lighting, PHOTO)

Social Environment / Relationships: (How do ppl in room interact / how are bodies organized in space and time? Who interacts with whom? What is the direction of communication? Who looks at whom – patient, interpreter, medical staff? Who initiates communication? Who speaks most often?)
Movement of Bodies / Activities: (Who is physically present in room, how are ppl moving in room, what functions do they perform - fill out paperwork, read, examine ppl using tools; who enters / leaves room and at which point in interaction)

Acts: (What roles do all those involved - patients, clinic staff, interpreters - fulfill during the clinical encounter?)

Meanings: (What is the intended purpose of the interaction or acts that occur during the interaction? Whose interpretation of the intended purpose is it?)

NOTES:
Appendix J  Interview Guides

Interview Guide – TB Clinic Recruitment
Study Title: Social Perspectives on Tuberculosis and Immigration

1. Tell me about your immigration journey to Canada.
   - Why did you come here?
   - How has immigration changed your life?

2. Describe what your life was like back home.
   - Tell me how you lived.
   - What are some of the best and worst things about living back home?

3. What is life like here for you?
   - How different is life here in Canada from what you expected it to be?
   - Do you feel you’re well established?

4. How did the diagnosis of TB / LTBI (OR / IMS overall, if no TB / LTBI) interfere with your migration experience?
   - When you were told you (may) have TB / LTBI, how did that change your life as an immigrant in Canada?
   - Tell me about the Immigrant Medical Examination (IME).
   - How did screening for tuberculosis affect your experience at the border (airport) when coming into Canada?
   - How did you come into contact with Public Health officials in Canada?

5. How did you end up at the tuberculosis clinic at St. Michael’s Hospital?
   - Who told you that you have to go to the tuberculosis clinic there? How did this happen?
   - At what point in your immigration process did this happen?

6. Tell me about your experience at the tuberculosis clinic.
   - Who did you talk to? What did they say?
   - What did you have to do while you were there?

7. How has your thinking about tuberculosis changed during this process?
   - How did you used to think about tuberculosis before coming to Canada?
   - How do you think about it now?
   - If you think differently now, what made you change your mind?

Interview Guide (Accept Prophylaxis)
Social Perspectives on TB and Immigration, Version Date 13 Nov. 2014
8. Do you think of yourself as someone who has tuberculosis? Please explain.
   - Because of your LTBI diagnosis, do you think of yourself as someone who is or was sick? Why or why not?
   - Out of your friends and family, who did you talk to about tuberculosis when you were told you have LTBI?
   - How has this affected your relationships?

9. Tell me about your decision to take preventive treatment (if LTBI diagnosed).
   - How did you come to this decision? Why?
   - Did someone help you make this decision? Tell me about this.
   - If you have started the treatment, explain to me how it works (how often you have to take medicine, when, for how long etc.).

10. If you could improve this process for immigrants in the future (process of immigration, medical screening and treatment for TB) what would you change and why? How?
   - What would you do differently if you had to immigrate to Canada from your home country all over again?

11. Is there anything important that you would like to say? Anything that you think I should know but haven’t asked about?

Question #9 in Interview Guide (if diagnosed or suspected LTBI and Rejected Prophylaxis) changes to:
9. Tell me about your decision not to take preventive treatment.
   - How did you come to this decision? Why?
   - Did someone help you make this decision? Tell me about this.
   - Do you think you will ever take treatment in the future? Why?
Interview Guide – Public Health Recruitment
Study Title: Social Perspectives on Tuberculosis and Immigration

1. Tell me about your immigration journey to Canada.
   - Why did you come here?
   - How has immigration changed your life?

2. Describe what your life was like back home.
   - Tell me how you lived.
   - What are some of the best and worst things about living back home?

3. What is life like here for you?
   - How different is life here in Canada from what you expected it to be?
   - Do you feel you’re well established?

4. How did you end up having to undergo TB Medical Surveillance / be tested for TB?
   - Who told you that you have to be tested for TB? How did this happen?
   - How did you come into contact with Public Health officials in Canada?
   - At what point in your immigration process did this happen?

5. Tell me about your experience at the tuberculosis clinic.
   - Who did you go to see about this? (Family doctor, TB clinic, walk-in clinic, etc.)
   - Who did you talk to? What did they say?
   - What did you have to do while you were there?

6. Your tests for TB resulted in a diagnosis of (active TB / LTBI / no TB). How did this diagnosis affect your migration experience?
   - When you were told you (may) have tuberculosis, how did that change your life as an immigrant in Canada?
   - Tell me about the Immigrant Medical Examination (IME).
   - How did screening for tuberculosis affect your experience at the border (airport) when coming into Canada?

7. How has your thinking about tuberculosis changed during this process?
   - How did you used to think about tuberculosis before coming to Canada?
   - How do you think about it now?
   - If you think differently now, what made you change your mind?
8. Do you think of yourself as someone who has tuberculosis? Please explain.
   - Because of your diagnosis, do you think of yourself as someone who is or was sick? Why or why not?
   - Out of your friends and family, who did you talk to about tuberculosis when you were told you may have it?
   - How has this affected your relationships?

9. a) Tell me about your treatment [for active TB]. OR
   b) Tell me about your decision to treat/not to treat LTBI [for LTBI]. OR
   c) If/when you were told you may have LTBI, would you have treated it? [for no TB/LTBI]
      Why, or why not?
      - How did you come to this decision? Why?
      - Did someone help you make this decision? Tell me about this.
      - Do you think you will ever take treatment in the future? Why? [if applicable]
      - If you have started the treatment, explain to me how it works (how often you have to take medicine, when, for how long etc.).

10. If you could improve this process for immigrants in the future (process of immigration, medical screening and treatment for TB) what would you change and why? How?
    - What would you do differently if you had to immigrate to Canada from your home country all over again?

11. Is there anything important that you would like to say? Anything that you think I should know but haven’t asked about?
### Appendix K  Critical Incident Charts*

#### Critical Incident Chart: (In-Canada PR Applicant; sponsored; not TB/no LTBI)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct. 2014</td>
<td>1$^{st}$ chest x-ray (CXR) – abnormality identified; read by radiologist</td>
<td>(out-of-pocket expense)</td>
<td></td>
</tr>
<tr>
<td>Nov. 2014</td>
<td>Employer requested consultation w/ pulmonologist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan. 2015</td>
<td>Walk-in clinic GP did x-ray; said referral to pulmonologist not necessary – CXR abnormality not health concern</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar. 2015</td>
<td>Last CXR taken at employer’s request before quitting job</td>
<td>_quit job back home; too much trouble to monitor / consult drs for employer; worried health history will cause problems @ Canadian border crossing</td>
<td></td>
</tr>
</tbody>
</table>

### BEGIN CIC APPLICATION PROCESS

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar. 2015</td>
<td>Turned away @ border when coming to visit for holidays (past criminal record); waited across border for few days filling out paperwork; border agents / immigration ‘guiding’ / helping applicant in the process</td>
<td>Visa Pilot program begins for open work permit for PR spouse applicants (for one year only)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>End of Apr. 2015</td>
<td>Return to home country from visit in Canada</td>
<td></td>
<td></td>
</tr>
<tr>
<td>End of May 2015</td>
<td>Completed requirement of criminal rehab; went to border crossing to have form signed by CIC agent</td>
<td>Police record check expires in 3 months</td>
<td></td>
</tr>
</tbody>
</table>

### CROSSING BORDER INTO CANADA

<table>
<thead>
<tr>
<th>Date</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>July 2015</td>
<td>Returned to Canada as visitor; court marriage in Canada (needed marriage certificate to include in CIC application)</td>
<td>1. DME 1$^{st}$ – required follow-up</td>
<td>If applying for PR post-landing, cannot leave Canada during application process</td>
</tr>
<tr>
<td>+ 3 weeks later</td>
<td></td>
<td>2. PP didn’t listen to applicant (had pre-existing abnormality on CXR) → PP flagged client for TB furtherance b/c of policy, ignoring context / med. history</td>
<td></td>
</tr>
<tr>
<td>Oct 2015</td>
<td></td>
<td>3. TB clinic referral for TB furtherance</td>
<td></td>
</tr>
<tr>
<td>Dec. 2015</td>
<td>Submitted complete application for PR to CIC</td>
<td>TB clinic results – no TB / no LTBI – MEDICAL CLEARANCE; made follow-up appt. for Sept. 2016 to ensure no change in CXR (non TB-related)</td>
<td></td>
</tr>
<tr>
<td>Dec. 2015 / Jan. 2016</td>
<td></td>
<td>Followed-up with PP → told application NOT complete → needs CXR from TB clinic; contacted TB clinic to ask for req’d documents etc. to forward to PP → physically delivered CXR form TB clinic to PP; PP questioned authenticity of clearance form TB specialist due to follow-up appt. made or Sept. 2016 → requested his own investigation / reading of CXR</td>
<td></td>
</tr>
</tbody>
</table>

### RESEARCH PARTICIPATION ENDS – IMMIGRATION PROCESS ONGOING

* Some details (i.e. pseudonyms, countries of origin, etc.) have been omitted and dates have been changed (but time intervals between critical incidents remain the same) to protect participants’ identities.
### Critical Incident Chart: (In-Canada PR Applicant; Primary Applicant; LTBI?)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 2008 – Oct. 2009</td>
<td>Began CIC application process after returning home from visit</td>
<td>Required vary basic health history – no IME (exempt)</td>
<td>Visited family in Canada</td>
</tr>
<tr>
<td>June 2009</td>
<td>Moved to Canada for school as int'l student (Student Visa)</td>
<td></td>
<td>Started college</td>
</tr>
<tr>
<td>June 2010</td>
<td>Received “school &amp; work visa”</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan 2014</td>
<td>Work permit received</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar. 2015</td>
<td>PR application received; notification from CIC to pay application fee; inquired with CIC about work permit/VISA renewal (expiring soon) → told renewal not necessary</td>
<td>Received referral for IME (within 30 days)</td>
<td></td>
</tr>
<tr>
<td>+ 3 days</td>
<td></td>
<td>1. 1st IME appointment with PP 3 days later</td>
<td></td>
</tr>
<tr>
<td>+ few weeks</td>
<td>Inquired with CIC about work permit/VISA renewal again → again told renewal was necessary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr. 2015</td>
<td>Work permit/VISA expired, as instructed by CIC</td>
<td>Informed employer about problem with paperwork</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Inquired with CIC about work permit/VISA renewal again → told renewal IS necessary</td>
<td>Unable to work legally → unemployed</td>
<td></td>
</tr>
<tr>
<td>Apr. / May 2015</td>
<td>Received new application for work permit / VISA renewal from CIC agent</td>
<td>Passport from country of origin expiring soon needed to renew passport before submitting CIC work permit / VISA renewal application</td>
<td></td>
</tr>
<tr>
<td>May 2015</td>
<td>Submitted new CIC work permit / VISA application (90-day deadline)</td>
<td>Passport renewed; CIC application cost extra $ because expired</td>
<td></td>
</tr>
<tr>
<td>June 2015</td>
<td>2. TB furtherance – 1st TB clinic appointment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug. 2015</td>
<td>3. TB furtherance – follow-up appointment – MEDICAL CLEARANCE from TB specialist</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 7 days</td>
<td>Back &amp; forth b/w PP &amp; TB specialist: called PP to get update – told CXR is missing from TB clinic &amp; clearance letter not received; called TB clinic to notify that PP needs CXR; told by TB specialist that no follow-up CXR required; called PP (3 week delay b/c clinic on vacation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 3 weeks</td>
<td>PP told client he needs 2nd CXR from follow-up at TB clinic; called TB clinic to relay info → TB clinicians confused, said 2nd CXR not required; physically returned to PP to relay info from TB clinic; PP explained that without 2nd CXR IME not complete and cannot submit application; participant got 2nd CXR done from PP’s clinic; returned to PP and physically provided CXR → ensured application</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>submitted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Sept. 2015</strong></td>
<td>CIC response RE work permit / VISA application → informed that WRONG APPLICATION FORM WAS SUBMITTED; given 30 days to LEAVE CANADA (no official legal status / paperwork)</td>
<td>Obtained CIC medical clearance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hired lawyer / contacted MP (parliament representative) → no help</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CROSSING BORDER TO LEAVE CANADA</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oct. 2015</strong></td>
<td>Return to home country</td>
<td>Waiting for PR application approval</td>
<td></td>
</tr>
<tr>
<td><strong>+ weeks</strong></td>
<td>CIC mistakenly notifies participant that they have not received IME results (eventually correct their mistake)</td>
<td>Traumatic experience for participant – separated from friends and family in Canada</td>
<td></td>
</tr>
</tbody>
</table>
### Critical Incident Chart: (In-Canada PR Applicant; Spouse; no TB)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>Car Accident – suspected TB; completed 4 months TB treatment → discontinued after negative TB test results; scar tissue on lungs → abnormal CXR for life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td>Temporarily living in [country name] for work</td>
</tr>
<tr>
<td>2009</td>
<td></td>
<td></td>
<td>Got married</td>
</tr>
<tr>
<td>2012</td>
<td>Spouse emigrated to Canada (International Student)</td>
<td></td>
<td>Living in home country</td>
</tr>
</tbody>
</table>

### BEGIN CIC APPLICATION PROCESS

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 2012</td>
<td>Applied to CIC for work permit/VISA</td>
<td>Pre-departure IME → abnormal CXR</td>
</tr>
<tr>
<td>Dec. 2012</td>
<td></td>
<td>Repeat CXR for IME with PP; explains to PP cause of abnormal CXR (known about it since 2007 – told about accident and ‘TB’ history); submitted all health records 2007-2012 to PP/CIC office in home country</td>
</tr>
<tr>
<td>Jan. 2013</td>
<td>Referral for ultrasound → no fluid found in lungs</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>TB furtherance referral; sputum test (different site); unable to produce sputum – told to return 1 week later</td>
<td>New hospital/new registration costs</td>
</tr>
<tr>
<td>+ 1 week</td>
<td>Returned for sputum test → unable to produce sputum</td>
<td>Refunded $ for test</td>
</tr>
<tr>
<td>July 2013</td>
<td>CIC work VISA approved</td>
<td>Referral for post-landing IMS</td>
</tr>
</tbody>
</table>

### CROSSING BORDER INTO CANADA

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 2013</td>
<td>Arrival in Canada</td>
<td>Applied for In-Canada PR; Contacted public health to start IMS → instructed to wait for OHIP (delay testing) IME referral received for May 2014 (delay of 1.5 years)</td>
</tr>
<tr>
<td>Nov. 2013</td>
<td>Family Dr. visit → start IMS testing prior to OHIP (1); CXR, TST → referral to TB clinic for March 2014</td>
<td>Received OHIP; fear &amp; anxiety from unknown TB diagnosis</td>
</tr>
<tr>
<td>Nov. 2013</td>
<td>Urgent referral to TB clinic (non-IMS related) → consultation to ensure pregnancy is safe if unknown TB status → received clearance for pregnancy</td>
<td></td>
</tr>
<tr>
<td>Nov. 2013</td>
<td></td>
<td>Became pregnant</td>
</tr>
<tr>
<td>Mar. 2014</td>
<td>1. TB clinic IMS (consult. only); no diagnostics / no CXR (pregnant); compared CXR from Nov. to old CXRs (2007-2012); must return for follow-up post partum</td>
<td></td>
</tr>
<tr>
<td>Sept. 2014</td>
<td>2. TB clinic IMS follow-up appt.; CXR but no sputum (delayed due to breastfeeding)</td>
<td></td>
</tr>
<tr>
<td>Oct. 2014</td>
<td>3. TB clinic IMS follow-up; CXR and sputum test</td>
<td></td>
</tr>
<tr>
<td>~ Dec. (7) 2014</td>
<td>Sputum test results negative</td>
<td>No TB clinic appt.</td>
</tr>
<tr>
<td>Mar. 2015</td>
<td>4. TB clinic IMS follow-up; CXR; told that due to +TST result will prob. have to start proph (LTBI suspected) after no longer breastfeeding</td>
<td></td>
</tr>
<tr>
<td>May 2015</td>
<td>5. PR IME (in-Canada); Still undergoing IMS from</td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>Event</td>
<td></td>
</tr>
<tr>
<td>--------------</td>
<td>----------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>later May 2015</td>
<td>work/VISA application process; notified PP of IMS situation; submitted all Canadian CXRs from post-landing IMS</td>
<td></td>
</tr>
<tr>
<td>July 2015</td>
<td>5. TB clinic (IMS) follow-up appt.; CXR (visible improvement); to return for follow-up in Sept. 2015</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6. TB clinic (IMS) follow-up appt.; received medical clearance for IMS from TB specialist; no proph. Recommended (b/c improved CXR)</td>
<td></td>
</tr>
<tr>
<td>later July 2015</td>
<td>Submitted IMS discharge letter (proof of medical clearance) to CIC for PR application</td>
<td></td>
</tr>
<tr>
<td>end July 2015</td>
<td>PR application approved</td>
<td></td>
</tr>
<tr>
<td>Aug 2015</td>
<td>In-office PR landing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Received IMS referral for PR!!!</td>
<td></td>
</tr>
<tr>
<td>+ 3 days</td>
<td>Received IMS exemption / clearance for PR application process</td>
<td></td>
</tr>
<tr>
<td></td>
<td>After all the tests, participant still said about TB diagnosis: “I still don’t know” LTBI? No TB?</td>
<td></td>
</tr>
</tbody>
</table>
# Critical Incident Chart: (Overseas PR Applicant; Spouse; active TB found through IME)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1960s</td>
<td>Had TB because had “fluid in my lungs”; treated for active TB disease for 6 months</td>
</tr>
<tr>
<td>2006</td>
<td>Spouse moved to Canada</td>
</tr>
</tbody>
</table>

**BEGIN CIC APPLICATION PROCESS**

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>Submitted CIC application (1st time)</td>
</tr>
<tr>
<td></td>
<td>1. IME completed for applicant and accompanying children</td>
</tr>
<tr>
<td>2011-2012</td>
<td>Submitted CIC application (2nd time)</td>
</tr>
<tr>
<td></td>
<td>2. Repeated IME → active TB disease; treatment for 8 months then completed IME and received Medical Clearance</td>
</tr>
<tr>
<td>2014</td>
<td>Submitted CIC application (3rd time)</td>
</tr>
<tr>
<td></td>
<td>Spouse (as primary applicant) followed up with CIC → needed to resubmit application (told a different immigration officer taking care of their file)</td>
</tr>
<tr>
<td>?</td>
<td>CIC application approved&lt;br&gt;IMS referral</td>
</tr>
</tbody>
</table>

**CROSSING BORDER INTO CANADA**

<table>
<thead>
<tr>
<th>Event</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 2014</td>
<td>Arrived in Canada</td>
</tr>
<tr>
<td></td>
<td>Went to Service Ontario days after arriving to ask about IMS Handout → felt stigmatized and left, crying; went to 2nd Service Ontario location → referred to a doctor</td>
</tr>
<tr>
<td>+ weeks</td>
<td>3. Went to walk-in clinic (assisted by family living in Canada); CXR referral (had to go a few times); blood work, sputum → referral to TB clinic</td>
</tr>
<tr>
<td>June (?) or July 2014</td>
<td>4. Community health centre visit (family helped to take participant to appointment) → received “verbal confirmation” from doctor that does not have active TB disease</td>
</tr>
<tr>
<td>+ days or weeks</td>
<td></td>
</tr>
<tr>
<td>+ days or weeks</td>
<td></td>
</tr>
<tr>
<td>Aug. 2015</td>
<td>5. TB clinic IMS appointment; repeat sputum</td>
</tr>
<tr>
<td>Oct. 2015</td>
<td>6. TB clinic follow-up → sputum results → received verbal medical clearance</td>
</tr>
</tbody>
</table>

Uncertain whether IMS complete
<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>May – July 2011</td>
<td>Family in Canada applied for participant to come to Canada as PR (Family reunification)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2012</td>
<td>Missed submission deadline for CIC application → received letter 3 days before deadline (problems with post office)</td>
<td></td>
<td>Became pregnant (unknown at the time)</td>
</tr>
<tr>
<td>July 2012</td>
<td></td>
<td>Gynecologist appt → pregnancy undetected</td>
<td></td>
</tr>
<tr>
<td>Aug. 2012</td>
<td>Family in Canada re-applied with CIC for PR for participant and the child</td>
<td>Active TB diagnosed &amp; pregnancy detected (not in context of immigration); admitted to hospital, in isolation (1 month); began 6 month treatment (daily regimen) for active TB (until July 2013)</td>
<td></td>
</tr>
<tr>
<td>Sept. 2012</td>
<td>Discharged from hospital – put on DOT (officially)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec. 2012</td>
<td>Admitted to hospital @ full term before giving birth; TB testing prior to birth → sputum, CXR; cleared of active TB → reimen 1 pill every other day for 2 months (until July 2013); Gave birth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb. 2013</td>
<td>Completed treatment for active TB</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec. 2013</td>
<td>Received CIC notice to report for IME</td>
<td>Made IME appointment immediately after received notice; disclosed TB history → prepared and supplied medical files &amp; documentation to PP; told about IMS referral</td>
<td></td>
</tr>
<tr>
<td>+ 2 days</td>
<td></td>
<td>TB furtherance: blood work, CXR, sputum; report faxed to CIC 2 days later</td>
<td></td>
</tr>
<tr>
<td>? Feb / March 2014</td>
<td>Family from Canada sent lawyer with CIC papers for participants to sign</td>
<td></td>
<td></td>
</tr>
<tr>
<td>June / July 2014</td>
<td>Received notification from CIC that papers (brought by lawyer) must be faxed, not mailed; participant faxed CIC application papers and passport to embassy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sept. 2014</td>
<td>CIC application approved</td>
<td>Referral for IMS</td>
<td>Had to borrow $ to pay for CIC application; Became pregnant (unknown at the time)</td>
</tr>
<tr>
<td>Oct. 2014</td>
<td></td>
<td></td>
<td>Had to ask others to help borrow $ to pay for plane ticket etc. (in rush before child turns 2 year old to save $ on airfare)</td>
</tr>
</tbody>
</table>

**CROSSING BORDER INTO CANADA**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov. 2014</td>
<td>Arrival in Canada</td>
</tr>
<tr>
<td></td>
<td>Received 2nd IMS handout @ airport</td>
</tr>
<tr>
<td>end Nov. 2014</td>
<td>Community health centre → Nurse Practitioner (NP) assessment → pregnancy detected → IMS postponed; NP faxed IMS handout to Public Health to notify about pregnancy</td>
</tr>
<tr>
<td>Date</td>
<td>Immigration-Related Critical Incident (Non-Medical)</td>
</tr>
<tr>
<td>--------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>~ 2008</td>
<td>Spouse moved to Canada</td>
</tr>
</tbody>
</table>

BEGIN CIC APPLICATION PROCESS

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>March 2014</td>
<td></td>
<td>1&lt;sup&gt;st&lt;/sup&gt; IME: CXR abnormal → referred for TB furtherance</td>
<td></td>
</tr>
<tr>
<td>May 2014</td>
<td></td>
<td>TB Furtherance: sputum induction</td>
<td>Attended clinic daily for one week in attempt to collect sputum; had to “pay twice…[for] the medical exam”</td>
</tr>
<tr>
<td>July 2014</td>
<td>CIC Application approved</td>
<td>Referred for IMS in Canada because of LTBI</td>
<td></td>
</tr>
<tr>
<td>Aug. 2014</td>
<td></td>
<td>Quit job</td>
<td></td>
</tr>
</tbody>
</table>

CROSSING BORDER INTO CANADA

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct. 2014</td>
<td>Arrival in Canada as PR</td>
<td>Contacted Public Health for IMS; instructed to wait with testing until receives OHIP (3 months)</td>
<td></td>
</tr>
<tr>
<td>Jan. 2015</td>
<td></td>
<td>1&lt;sup&gt;st&lt;/sup&gt; IMS medical assessment in walk-in clinic after receiving OHIP; CXR and TST → +TST and requisition for follow-up CXR</td>
<td>Received OHIP</td>
</tr>
<tr>
<td>+ 2 weeks</td>
<td></td>
<td>2&lt;sup&gt;nd&lt;/sup&gt; IMS - Repeat CXR → referral to TB clinic</td>
<td></td>
</tr>
<tr>
<td>May 2015</td>
<td></td>
<td>3&lt;sup&gt;rd&lt;/sup&gt; IMS – 1&lt;sup&gt;st&lt;/sup&gt; TB clinic initial visit: sputum, CXR; had concurrent tests (blood work and ultrasound for 2 other comorbidities at different hospital)</td>
<td></td>
</tr>
<tr>
<td>July 2015</td>
<td></td>
<td>4&lt;sup&gt;th&lt;/sup&gt; IMS – TB Clinic follow-up appointment: LTBI diagnosed; referral for CT scan of lungs; IMS verbal medical clearance form TB specialists</td>
<td></td>
</tr>
</tbody>
</table>

RESEARCH PARTICIPATION ENDS – IMMIGRATION PROCESS ONGOING
Critical Incident Chart: (In-Canada PR Applicant; common-law sponsorship; LTBI diagnosed during IME and started prophylaxis)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>March/April 2011</td>
<td></td>
<td></td>
<td>Completed university degree in home country</td>
</tr>
<tr>
<td>Aug. 2011</td>
<td></td>
<td></td>
<td>Vacationed in Canada; met current partner and decided to emigrate to Canada</td>
</tr>
</tbody>
</table>

**CROSSING BORDER INTO CANADA**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 2012</td>
<td>Arrival in Canada with work/study permit / VISA (1 year visa)</td>
</tr>
<tr>
<td>~April 2013</td>
<td>Approval of CIC application for after-study work permit (until ~April 2014)</td>
</tr>
<tr>
<td>~April 2014</td>
<td>Approval of CIC special work VISA for temporary workers from certain countries; closed work permit → unable to change jobs</td>
</tr>
</tbody>
</table>

**BEGIN CIC APPLICATION PROCESS FOR PR**

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>~Oct. 2015</td>
<td>Made up-front IME appointment with PP → 2 months wait time</td>
</tr>
<tr>
<td>Dec. 2015</td>
<td>IME with PP → abnormal CXR</td>
</tr>
<tr>
<td>+ 1 day</td>
<td>Submitted CIC PR application (sponsored by common-law partner); applied for open work permit until PR approved</td>
</tr>
<tr>
<td>+ 1 day</td>
<td>Returned to PP for sputum and repeat CXR → referral for TB furtherance to TB clinic (2 months wait time)</td>
</tr>
<tr>
<td>Feb. 2016</td>
<td>TB furtherance at TB clinic (initial visit): CXR &amp; sputum again (sputum collection with PP during IME ignored)</td>
</tr>
<tr>
<td>April 2016</td>
<td>TB clinic follow-up: LTBI diagnosis; started prophylaxis</td>
</tr>
</tbody>
</table>

**RESEARCH PARTICIPATION ENDS – IMMIGRATION PROCESS ONGOING**

376
## Critical Incident Chart: (Overseas PR Applicant; spouse sponsorship; no TB)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feb. 1993</td>
<td>Spouse (not yet married to participant) arrives in Canada</td>
<td></td>
<td>Participant marries spouse in home country</td>
</tr>
<tr>
<td>mid. 2008</td>
<td></td>
<td>Pneumonia (possibly underwent TB testing with doctor during clinical investigation when ill)</td>
<td></td>
</tr>
</tbody>
</table>

### BEGIN CIC APPLICATION PROCESS

| ~ 2010   | Begin compiling CIC application for PR – sponsored by spouse living in Canada | 1st IME & TB furtherance: 3-4 day process, required travel (very costly – travel by boat, accommodation, doctor’s fees, test fees); CXR and sputum; IMS results valid only for 1 year | Spouse had to send $ from Canada for immigration application / medical tests etc. |
| + > 1 year| Had to obtain passport, criminal check, marriage / birth certificates | To obtain necessary papers, required IME test results, but already expired → had to repeat IME |
| ?        | Requirements for different components of CIC application not all at the same time, expire at different times | Not enough $ to pay for all tests and paperwork processing at the same time; paperwork had to be staggered; lots of expiries and had to repeat; Application process took 4 years!! |

### CIC approval of application

### CROSSING BORDER INTO CANADA

<table>
<thead>
<tr>
<th>Jul. 2015</th>
<th>Arrival in Canada as PR</th>
<th>IMS referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aug. 2015</td>
<td>Public Health contacted participant for IMS; IMS assessment started at Public Health clinic → sputum collected; referred to TB clinic</td>
<td></td>
</tr>
<tr>
<td>Sept. 2015</td>
<td>1st TB clinic medical assessment for IMS; CXR</td>
<td></td>
</tr>
<tr>
<td>Nov. 2015</td>
<td>2nd TB clinic visit for IMS (follow-up); no TB → MAC; requisition for CT scan, sputum, TST</td>
<td></td>
</tr>
<tr>
<td>March 2016</td>
<td>3rd TB clinic visit for IMS (follow-up); repeat CXR</td>
<td>Must return in Jan. 2016 for results &amp; treatment options</td>
</tr>
</tbody>
</table>

RESEARCH PARTICIPATION ENDS – IMMIGRATION PROCESS ONGOING
## Critical Incident Chart: (Government-Sponsored Refugee; two cases of old treated TB)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>~2006-2007</td>
<td></td>
<td>Active pulmonary TB @ as teenager (6-month treatment); CXRs for diagnosis and follow-up</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CROSSING BORDER AS REFUGEE INTO INTERMEDIATE COUNTRY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td>Fled home country alone as refugee (in early 20s [age]); living in intermediate country as undocumented refugee; eventually recognized by UNHCR and obtained legal protection as refugee</td>
<td>Active TB (extrapulmonary) (start 9-month course of treatment); CXRs</td>
<td></td>
</tr>
<tr>
<td>~ Aug. 2012</td>
<td></td>
<td></td>
<td>Started working for UNHCR as volunteer</td>
</tr>
<tr>
<td>+ 3 months (~Nov. 2012)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 6 months (~May 2013)</td>
<td></td>
<td>TB treatment completed</td>
<td></td>
</tr>
<tr>
<td>+1 month (~June 2013)</td>
<td>1st follow-up for TB treatment -&gt; CXR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 3 months (~Sept. 2013)</td>
<td>2nd follow-up for TB treatment -&gt; CXR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 3 months (~Dec. 2013)</td>
<td>3rd follow-up for TB treatment -&gt; CXR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ Dec. 2013</td>
<td>CIC interview for re-settlement</td>
<td></td>
<td>Total time from CIC interview until arrival in Canada – 6 months</td>
</tr>
<tr>
<td>+ 2 weeks</td>
<td>IME with CIC -&gt; CXR (abnormal due to TB history)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 1 month</td>
<td>TB furtherance: repeat CXR -&gt; IMS referral for post-arrival in Canada</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CROSSING BORDER INTO CANADA</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>June 2014</td>
<td>Arrival in Canada (Saskatoon)</td>
<td>IMS referral</td>
<td>Participant intended to move to Toronto – Spoke with case worker about IMS and instructed to do IMS in Toronto</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 2 weeks</td>
<td>Moved to Toronto</td>
<td>Contacted by public health -&gt; referred for IMS; did not receive clear instructions, did not know how to complete IMS -&gt; attended immigration office (no help) -&gt; referred to a multicultural health and community services clinic (MHCSS)</td>
<td></td>
</tr>
<tr>
<td>July 2014</td>
<td></td>
<td>Inquired about IMS @ MHCSS -&gt; referred to a doctor on other end of GTA (walk-in clinic) for IMS</td>
<td></td>
</tr>
<tr>
<td>+ days</td>
<td>1st IMS with walk-in doctor; referral for CXR (@ different location); IMS forms completed but not submitted to public health (participant did not submit / assessing physician did not submit – neither knew</td>
<td>2 hours travel time; no OHIP – IFHP but only accepted for “limited services”, otherwise coverage rejected by walk-in doctor -&gt; had to pay for some services</td>
<td></td>
</tr>
<tr>
<td>+ ?</td>
<td>Public Health contacted participant → IMS forms missing (Participant felt threatened that will be deported unless IMS papers submitted ASAP)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ ?</td>
<td>Returned to MHCSS for IMS forms → instructed to call Public Health for forms; Received forms from public health (same forms as previously completed by assessing physician at walk-in)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sept. 2014</td>
<td>2nd IMS with walk-in doctor; required to complete exactly same forms as last time; IFHP rejected by doctor → had to cover cost $ out of pocket; CXR taken previously was not available to doctor b/c taken at another clinic → participant had to personally retrieve CXR from other location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ Sept./Oct. 2014</td>
<td>Received OHIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec. 2014</td>
<td>Became employed (no longer receiving monthly government assistance)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>summer 2015</td>
<td>Contacted by public health → instructed to repeat IMS with family physician (not explained why); participant had to ignore request for some time b/c overwhelmed with life circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~2 months</td>
<td>Applied for government assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct./Nov. 2015</td>
<td>3rd IMS (with family physician): CXR → abnormal; referral to TB clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>beginning 2016</td>
<td>Registered with a family physician after a long wait</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~Feb.-April 2016</td>
<td>4th IMS at TB clinic (initial visit): sputum done but refused CXR (agreed to provide CD with images of previous 2 CXRs taken in Canada – with walk-in and family doctors)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 2016</td>
<td>5th IMS at TB clinic (follow-up): sputum negative results; CXR taken; agreed to return in 6 months for final CXR / follow-up IMS; final IMS schedules for ~ Nov. 2016</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESEARCH PARTICIPATION ENDS – IMS PROCESS ONGOING
### Critical Incident Chart: (Temporary Resident – Int’l Student VISA; MAC – not TB / LTBI)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td></td>
<td></td>
<td>Started undergraduate degree in home country</td>
</tr>
<tr>
<td>Feb. 2013</td>
<td></td>
<td></td>
<td>Dropped out of university</td>
</tr>
<tr>
<td>Feb. 2015</td>
<td></td>
<td></td>
<td>Decided to pursue degree in Canada; began university application process</td>
</tr>
<tr>
<td>Aug. 2015</td>
<td></td>
<td></td>
<td>Received University admission acceptance in Toronto, Canada</td>
</tr>
</tbody>
</table>

#### BEGIN CIC APPLICATION PROCESS

| ~Sept./Oct. 2015 | Began CIC application process for Student Visa | IME: CXR abnormal → referral for CT scan the following day |
| + 2 weeks        | Referral for TB Furtherance; sputum test at another hospital in another city | 1 hour travel time to hospital for TB furtherance |
| end Dec. 2015    | CIC approval → received student Visa           | Forced to book last minute flight same day CIC approval was received to arrive in Canada in time for start of school year |

#### CROSSING BORDER INTO CANADA

<table>
<thead>
<tr>
<th>+ 5 days (Jan. 2016)</th>
<th>Arrival in Canada</th>
<th>Received IMS referral letter at airport</th>
</tr>
</thead>
<tbody>
<tr>
<td>+ 1 week</td>
<td>Contact public health for IMS (attended in-person); obtained IMS forms to be filled out by family physician</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>1st IMS appointment with doctor on campus: TST, CXR → abnormal but unclear – required to repeat</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Repeat CXR → abnormality visible; TST negative</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Repeat CXR again → abnormality confirmed; referral to TB clinic</td>
<td></td>
</tr>
<tr>
<td>April 2016</td>
<td>IMS at TB clinic (initial visit): CXR repeated, sputum collected, TB specialists asked for CT images from home country</td>
<td></td>
</tr>
<tr>
<td>June 2016</td>
<td>IMS at TB Clinic (follow-up): brought CT images for doctors; no TB / no LTBI → no treatment (grew MAC); received verbal medical clearance</td>
<td></td>
</tr>
</tbody>
</table>

#### RESEARCH PARTICIPATION ENDS – IMS PROCESS ONGOING
Critical Incident Chart: (Temporary Resident – Int’l Student VISA; suspected LTBI – refused prophylaxis)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006</td>
<td></td>
<td>Graduated university; began working</td>
<td></td>
</tr>
<tr>
<td><strong>BEGIN CIC APPLICATION PROCESS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>May 2014</td>
<td>Begin CIC application process for temporary residency – student and work visa; applied through immigration agent</td>
<td>Planning to come to Canada to start school in Sept. 2014</td>
<td>45 minutes travel time to CIC clinic. Referral for TB furtherance delayed process – unable to move to Canada by Sept. 2014 → had to defer starting school program in Canada</td>
</tr>
<tr>
<td>July 2014</td>
<td></td>
<td>1st IME appointment; CXR – abnormal → referral for TB furtherance; (may have repeated CXR before TB furtherance appointment but can’t remember for sure)</td>
<td></td>
</tr>
<tr>
<td>Sept. 2014</td>
<td>2nd IME appointment for TB furtherance. Sputum collected</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nov. 2014</td>
<td>3rd IME appointment – repeat CXR</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dec. 2014</td>
<td>CIC Application Approval (expires Dec. 2016)</td>
<td>Received referral for post-landing IMS; informed by CIC that tests for TB must be repeated in Canada</td>
<td></td>
</tr>
<tr>
<td><strong>CROSSING BORDER INTO CANADA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jan. 2015</td>
<td>Arrival in Canada</td>
<td>Contacted public health for IMS → referred to family physician for IMS medical assessment</td>
<td>Started school; monthly living expense not flexible (living on a strict budget)</td>
</tr>
<tr>
<td>~ Feb.-April 2015</td>
<td>1st IMS appointment (at walk-in clinic): blood test, CXR (covered under medical insurance); TST and appointment fee → had to pay out of pocket</td>
<td>$$$</td>
<td></td>
</tr>
<tr>
<td>+ ?</td>
<td>Public Health received results and explained they require further testing; participant asserts that will only complete IMS medical assessments if can do it at no cost (already spent $300–400 on tests – more than half of monthly budget)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ ?</td>
<td>Public health referral to TB clinic to complete IMS at no cost</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug. 2015</td>
<td>TB clinic IMS appointment (initial visit); CXR, sputum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oct. 2015</td>
<td>TB clinic IMS follow-up appointment: negative sputum → receives verbal medical clearance; suspected LTBI → recommended TST to confirm LTBI and prophylaxis; TST and prophylaxis refused by participant → wants to wait until receives CIC medical clearance</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESEARCH PARTICIPATION ENDS – IMS PROCESS ONGOING
## Critical Incident Chart: (Temporary Resident – Work permit; diagnosed LTBI – accepted prophylaxis)

<table>
<thead>
<tr>
<th>Date</th>
<th>Immigration-Related Critical Incident (Non-Medical)</th>
<th>Medical-Related Critical Incident</th>
<th>Other Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1999</td>
<td></td>
<td>Family member at home became sick with active TB → participant a household contact and (presumably) contracted LTBI</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>BEGIN IMMIGRATION APPLICATION PROCESS TO INTERMEDIATE COUNTRY</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2008</td>
<td>Apply for temporary work permit to intermediate country</td>
<td>IME for intermediate country: sputum, CXR, blood work → abnormal CXR → LTBI</td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Approval of work permit</td>
<td>Obtained medical clearance but referred for post-landing follow-up in intermediate country</td>
<td>Participant’s friend arrives in same intermediate country as temporary foreign worker (part of participant’s social network)</td>
</tr>
<tr>
<td>Dec. 2008</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CROSSING BORDER INTO INTERMEDIATE COUNTRY</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2009</td>
<td>Arrived in intermediate country</td>
<td>Had to report for medical assessment and follow-up to obtain medical clearance before allowed to begin working for employer; CXR → cleared for work, but required 2nd follow-up CXR → LTBI diagnosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>BEGIN CIC APPLICATION PROCESS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Submitted CIC application to come to Canada as temporary foreign worker through immigration agency</td>
<td>Followed in footsteps of friend – same immigration agency / same application process as friend</td>
<td></td>
</tr>
<tr>
<td>2010</td>
<td></td>
<td>Friend moved from intermediate country to Canada</td>
<td></td>
</tr>
<tr>
<td>April 2013</td>
<td>Received CIC work permit (found employed with the help of friend who was already living in Canada)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>?</td>
<td></td>
<td>IME: CXR abnormal – referral for TB furtherance → sputum</td>
<td>CIC clinic nearby (30-minute commute); delays in application process due to IME and TB furtherance process</td>
</tr>
<tr>
<td>+ 3 months</td>
<td>CIC application approved</td>
<td>Received medical clearance; referral for post-landing IMS in Canada</td>
<td></td>
</tr>
<tr>
<td><strong>CROSSING BORDER INTO CANADA</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2014</td>
<td>Arrived in Canada; questioned by border agents about 1 year delay from obtaining work permit and arrival in Canada → delays due to TB furtherance</td>
<td>Received IMS handout at border upon entry to Canada</td>
<td>Started working</td>
</tr>
<tr>
<td>+ days / weeks</td>
<td>Participant’s employer contacted public health for IMS</td>
<td>Participant quit her job - employer broke terms of contract / exploitative work circumstances → UNEMPLOYED (but soon begins working ‘illegally’ to survive)</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>April 2014</td>
<td>Lost legal work permit when quit job - started looking for another employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 1 day</td>
<td>Interview with new potential employer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ April / May 2014</td>
<td>New employer submitted application for Labour Market Opinion (LMO) to hire international worker (needed approval before CIC application for participant’s work permit can be submitted)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>Public Health was notified that participant was unemployed → referral to see a general practitioner for IMS assessment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>?</td>
<td>IMS medical assessment at walk-in clinic: sputum, CXR, blood test; results forwarded to Public Health → received referral to TB clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ July / Aug 2014</td>
<td>LMO rejected because wrong form filled out → must submit Labour Market Impact Assessment (LMIA) instead of LMO (Canadian policy changed) → must start process again</td>
<td>Mandatory 3 month wait period required for employer to have job ad before can submit LMIA application for participant → delay until Nov. / Dec. 2014</td>
<td></td>
</tr>
<tr>
<td>Oct. / Nov. 2014</td>
<td>1st IMS medical assessment at TB clinic (initial visit): sputum (unknown if CXR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ Nov. / Dec. 2014</td>
<td>Submitted LMIA application</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feb. 2015</td>
<td>2nd IMS at TB clinic (follow-up visit): unknown if CXR; TST done previously at some point (has picture of induration); counseled on LTBI &amp; prophylaxis → must return in 6 months for follow-up and then decide if wants to begin prophylaxis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>+ 1 week (Feb. 2015)</td>
<td>Underwent operation (cause / condition not disclosed during research interview)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>~ Feb. / March 2015</td>
<td>LMIA application approved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>March 2015</td>
<td>Participant’s immigration agent submitted LMIA to CIC for work permit → 120 day processing time (expected approval in ~ Sept 2015)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aug. 2015</td>
<td>3rd IMS at TB clinic (second follow-up visit): CXR and blood work. LTBI confirmed. Participant started prophylaxis</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RESEARCH PARTICIPATION ENDS – IMMIGRATION PROCESS ONGOING
### Appendix L  Data Analysis: Codes

<table>
<thead>
<tr>
<th>CODE</th>
<th>DEFINITION(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>‘at risk’ subject</td>
<td>risk of reactivating LTBI infection; ‘at risk’ of becoming sick; “take responsibility for yourself”</td>
</tr>
<tr>
<td>“for your own health”</td>
<td>imperative to health</td>
</tr>
<tr>
<td>challenging experts</td>
<td>dissent as a form of resistance</td>
</tr>
<tr>
<td>citizenship rights vs responsibilities</td>
<td></td>
</tr>
<tr>
<td>client (as consumer)</td>
<td>“a person or group that uses the professional advice or services of a [professional]” (Dictionary.com April 9); a patron or “paying guest” (immigrant status in Canada as paying guest?)</td>
</tr>
<tr>
<td>client (as recipient of social benefits)</td>
<td>“a person who is receiving the benefits, services, etc., of a social welfare agency, a government bureau, etc.” (Dictionary.com April 9, 2017)</td>
</tr>
<tr>
<td>coercion</td>
<td>coercion and persuasion are forms of NEGOTIATING power, i.e. attempt to “appeal to one’s sense or moral duty as persuasion”</td>
</tr>
<tr>
<td>confession</td>
<td></td>
</tr>
<tr>
<td>cost vs benefit</td>
<td>self-government for benefits that come with citizenship; cost vs. benefit of treatment</td>
</tr>
<tr>
<td>‘developed’ country vs. ‘developing’</td>
<td>power relations b/w patients/clients and medical/pub. health experts</td>
</tr>
<tr>
<td>country</td>
<td></td>
</tr>
<tr>
<td>discourse of fear</td>
<td></td>
</tr>
<tr>
<td>discourse of stigma</td>
<td></td>
</tr>
<tr>
<td>discourses of abuse</td>
<td></td>
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<tr>
<td>discourses of suspicion</td>
<td></td>
</tr>
<tr>
<td>diseased / ‘infected’ / ‘contagious’ /</td>
<td>wearing mask; also aesthetics (skinny, weak, coughing etc.); as a “vector of contagion” (Petersen &amp; Lupton, 1996, p. 78)</td>
</tr>
<tr>
<td>‘contaminated’ body</td>
<td></td>
</tr>
<tr>
<td>duties discourse</td>
<td></td>
</tr>
<tr>
<td>entrepreneurial self</td>
<td>the ‘healthy’ citizen requires the entrepreneurial self (my own note); “the self who is expected to live life in a prudent, calculating way, and to be ever-vigilant of risks” (Petersen &amp; Lupton, 1996, p. xiii)</td>
</tr>
<tr>
<td>expert advice / expert knowledge vs lay</td>
<td></td>
</tr>
<tr>
<td>lay knowledge / subjective understanding</td>
<td></td>
</tr>
<tr>
<td>expert vs. non-expert (subjugated</td>
<td></td>
</tr>
<tr>
<td>knowledges)</td>
<td></td>
</tr>
<tr>
<td>health professional expert as a</td>
<td>helps to identify the problem and offers advice / support (Petersen &amp; Lupton, 1996, p. 155)</td>
</tr>
<tr>
<td>resource</td>
<td></td>
</tr>
<tr>
<td>health promotion / education</td>
<td></td>
</tr>
<tr>
<td>healthy body</td>
<td>healthy weight, strength etc.; free of disease / infection</td>
</tr>
<tr>
<td>‘importer of disease’</td>
<td>Subjectivity; Immigrants with LTBI</td>
</tr>
<tr>
<td>private vs. public practices</td>
<td>how discourses affect individuals’ self-conduct in the public sphere vs. private sphere, i.e. Stacey removing mask in private during her stay at the hospital for active TB treatment</td>
</tr>
<tr>
<td></td>
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<td>---------------------------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>punishment</strong></td>
<td></td>
</tr>
<tr>
<td><strong>resistance</strong></td>
<td></td>
</tr>
<tr>
<td><strong>rewards</strong></td>
<td></td>
</tr>
<tr>
<td><strong>rights discourse</strong></td>
<td></td>
</tr>
<tr>
<td><strong>risk discourses</strong></td>
<td>epidemiological risk, specific to TB reactivation and infecting others</td>
</tr>
<tr>
<td><strong>'risky' subject</strong></td>
<td>risk of transmission – 'risky' to others, 'contaminating'; risky: as a “vector of contagion” (Petersen &amp; Lupton, 1996, p. 78); “take responsibility for others”</td>
</tr>
<tr>
<td><strong>self-governance</strong></td>
<td>self-surveillance / self-discipline</td>
</tr>
<tr>
<td><strong>subject agency / resistance</strong></td>
<td></td>
</tr>
<tr>
<td>the 'foreign' citizen</td>
<td>newcomer (temporary or permanent resident), but not political Canadian citizen; may not have equal status or complete access to rights and benefits as Canadian-born or naturalized citizens, but are expected to display equal investment in the obligations that come with citizenship (i.e. be a ‘good’ citizen) with a promise of potential reward in the form of naturalized citizenship in the future; must prove themselves first</td>
</tr>
<tr>
<td>the 'good' citizen</td>
<td>one who follows the rules as well as an entrepreneurial neo-liberal subject</td>
</tr>
<tr>
<td>the 'healthy' citizen</td>
<td></td>
</tr>
<tr>
<td>the 'policing expert'</td>
<td></td>
</tr>
<tr>
<td>the expert (doctor, public health official)</td>
<td></td>
</tr>
<tr>
<td>the fraudulent applicant / fraudulent subject</td>
<td></td>
</tr>
</tbody>
</table>
Appendix M  Confidentiality Agreements for Interpreters & Transcriptionist

Privacy and Confidentiality Agreement

I acknowledge and understand that:

- St. Michael’s Hospital (the “Hospital”) has in place policies and procedures respecting privacy, confidentiality and security (the “Policies and Procedures”),
- the Policies and Procedures are available to me upon request where I have any questions relating to my obligations hereunder,
- all personal health information [i.e., information identifying an individual and relating to the provision of health care to that individual] and/or confidential information [i.e., information relating to the business of the Hospital] that I have access to or learn through my employment, relationship or affiliation with The Hospital is to be treated as strictly private and confidential.
- as a condition of my employment, relationship or affiliation with The Hospital, I must comply with the Hospital’s Policies and Procedures, and
- if I fail to comply with those obligations, the Hospital may terminate my employment, relationship or affiliation with the Hospital and that I may be subject to legal action taken against me by the Hospital and others, and/or to report to the appropriate college or regulatory body

I agree that I will access, use or disclose any personal health information and/or confidential information that I learn of or possess because of my employment, relationship or affiliation with The Hospital, only if it is necessary for me to do so in order to perform my duties as assigned by the Hospital. I also understand that under no circumstances may personal health information and/or confidential information be communicated either within or outside of The Hospital except to such other persons as are authorized by The Hospital to receive such information.

I agree that I will not alter, destroy, copy or interfere with this information, except with authorization and in accordance with the policies and procedures.

I agree to keep any computer access codes assigned to me (for example, passwords) confidential and secure. I also agree to safeguard physical access devices (for example, keys, badges) and the privacy and confidentiality of any information being accessed.

I agree that I will not lend my access codes or devices to anyone and will not attempt to use those of others. I understand that access codes come with legal responsibilities and that I am accountable for all work done under these codes. I am aware that work done using such codes may be audited. If I have reason to believe that my access codes or devices have been compromised or stolen, I agree to immediately contact the Hospital’s Help Desk (ext. 5751).

Michelle X. Xin
Name (Please Print)

SMH Barcode Number
3/10/2015
Date

Form No. 69709 Rev 11/04
Privacy and Confidentiality Agreement

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Jing Zhao
Name (Please Print)

SMH Barcode Number

Signature

Date

Form No. 69709 Rev 11/04
CONFIDENTIALITY AGREEMENT
Transcription Services

Study Title: Social Perspectives on Tuberculosis (TB) and Immigration

Principal Investigator: Martyna A. Janjua, MA, PhD Candidate, Dalla Lana School of Public Health, University of Toronto

I, Lynne Pili, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Martyna Janjua related to her doctoral study.

Furthermore, I agree to:

1. Hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents.

2. Not discuss the content of the audio-taped interviews with anyone other than Martyna Janjua.

3. Not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Martyna Janjua.

4. Store all study-related audiotapes and computerized files on my password-protected computer or on an encrypted USB flash drive.

5. Return all audiotapes and study-related documents to Martyna Janjua in a complete and timely manner.

6. Permanently delete all electronic files containing study-related documents from my computer hard drive (including computer recycling bin) and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber’s name (printed) Lynne Pili

Transcriber’s signature

Date: May 13th, 2016