

**Article**

**Producing Bodies and Borders:  
A Review of Immigrant Medical  
Examinations in Canada**

**Sarah Wiebe**

University of Victoria, B.C., Canada. mailto: [swiebe@uvic.ca](mailto:swiebe@uvic.ca)

---

**Abstract**

Anxiety about our borders is not a new phenomenon. Distrust of immigrants, external threats, fraud and efforts to secure borders to deflect risky outsiders features prominently in political paranoia today and has since the fortification of state boundaries. This article is concerned with such anxiety and paranoia as it shapes Canadian political discourse, policy and practice in efforts to secure our borders and keep out potential risks. These risks – the poor, the unhealthy, the fraudulent – operate as real concerns for our political elite. Despite liberalized changes to border technologies, specifically citizenship and immigration legislation and practice, I argue that the assumptions about these ‘risks’ remain.

---

Building on the initial opinion piece previously published in *Surveillance & Society*, this article offers a more detailed investigation of historical shifts and trends of border technologies with respect to immigration policy and legislation and biological screening through the use of medical examinations in Canada (Wiebe 2008). This investigation does not claim to prescribe solutions to such complexities; however, the goal of this project is more than to describe a troublesome picture of Canadian citizenship and immigration. By unravelling some of the (dis)continuities throughout Canada’s immigration policies and practices, I offer a critical review of technologies past and present in pursuit of making some of the less visible exclusions and practices more visible. I believe this type of research is crucial to unsettle assumptions and help us challenge the myths and stereotypes that shape policy in this field. In doing so, I aim to problematize the productive and inclusive discourse encompassing the notion of the humanitarian, hospitable Canadian. I examine how this myth propagates the very (in)visible exclusions embedded within our immigration technologies.

Despite changes made in order to liberalize and in essence, I argue, ‘humanitarianize’ citizenship and immigration practices over the last century, this paper argues that fundamental historical assumptions about foreigners, which discriminate against others and stigmatize ‘strangers’, remain embedded within contemporary policy and practice, despite a discursive veil of inclusive and liberal legislation. While explicit exclusions have been formally removed from the legislative discourse with the introduction of the points system in 1967, analysis of the existing immigration technologies reveal a more *productive*, yet equally problematic discourse about population welfare and a healthy public in Canada. These legal and discursive modalities depict historical fear and pre-existing assumptions about non-citizens as threats to the Canadian population. By evaluating legislation, policy, operational manuals and political discourse, I decipher some assumptions about non-citizens as potential threats and how these threats are crafted vis-à-vis hospitable and humanitarian Canadians.

Wiebe, Sarah. 2009. Producing Bodies and Borders: An Review of Immigrant Medical Examinations in Canada. *Surveillance & Society* 6(2): 128-141.

<http://www.surveillance-and-society.org> | ISSN: 1477-7487

© The author(s), 2009. | Licensed to the Surveillance Studies Network under a [Creative Commons Attribution Non-Commercial No Derivatives license](https://creativecommons.org/licenses/by-nc-nd/4.0/).

## Theoretical Frame

Although this paper is not a study of theories of biopolitics or governmentality, I believe that these conceptual frameworks provide much insight into how we think about borders in Canada, especially with respect to the use of immigrant medical examinations. Immigration technologies and border policies, with a specific emphasis on immigrant medical examinations, can be understood as assemblages. In this paper, an assemblage refers to historically constituted regimes or practice of elements deriving from historical trajectories. These polymorphous regimes, in their internal and external relations, bear upon a multiple and wide range of problems and issues. From the perspective of governmentality, formal institutions of government and the law play a part in the operation of these assemblages; however, neither immigration policies nor the border can be reducible solely to the state or to law. The state, from this approach, is a decentred locus of power, which executes law as an instrument (Foucault 1994). The focus of analysis here does not rely on conceptions of formal government institutions, but evaluates various processes and technologies governments use to shape, guide and direct the conduct of its (non)citizens. The operation of power, in this context, is not a centralized exercise from a sovereign authority, but a compilation of ubiquitous and dispersed technologies.

This theory of governance requires that we not only pay attention to the source of power, but also its techniques, strategies and effects. In this regard, power is not exclusively negative or repressive. Power must also be considered as productive, insofar as it produces reality and domains of objects, rituals and truths. Following this conception of power and governance, this paper analyzes immigration technologies which focus not solely on negative or coercive border practice, but also how these technologies produce historically specific designs of ‘the border’, ‘Canadian identity’, ‘citizenship’ and ‘(un)worthy citizens’. The border in this article refers to what Anna Pratt calls a ‘contingent and artful accomplishment’, meaning it is continuously constituted and reconstituted at a variety of delocalized sites through assemblages of intersecting authorities, technologies and forms of knowledge (Pratt 2005: 11). It is a flexible sociological construct that plays a crucial role in the continuous regulation of the identities of citizens, immigrants, refugees, criminals and the list goes on.

This art of government seeks to rule, shape and guide the conduct of citizens in the name of health, wealth and the welfare of the population. Within governmental modes of rule, economics are essential features of state management. This rule includes the emergence of apparatuses of security, which include the use of standing armies, police forces, diplomatic corps, intelligence services and spies, but also health, education and social welfare systems and the mechanisms of the management of the national economy.

The state expresses its goals through the qualified life of its citizenry. As Michel Foucault articulates, biopolitics in our modern era refers to the governance of *life itself*. The governance over life centres on several elements. One element is the conception of the body as a machine:

its disciplining, the optimization of its capabilities, the extortion of its forces, the parallel increase of its usefulness and its docility, its integration into systems of efficient and economic controls, all this was ensured by the procedures of power that characterized the disciplines: an anatomo-politics of the human body (Foucault 1978).

Another element of this control, as Foucault argues, is the supervision of the body operating as a series of regulatory controls. In the later sense, political power operates through a series of technologies where administrative bodies carefully calculate and manage *life itself*. This appears in governmental population management strategies as officials examine a species body more broadly. In this respect, I understand the regulatory controls of screening the health of potential citizen bodies as a biopolitics of the population. Life itself is carefully calculated and managed in order to achieve the material, productive, economic goals of the state. A close examination of citizenship and immigration technologies in Canada reveals the operation of biopolitics.

## Biopolitics and Border Technologies in Canada

The creation of immigration policies and laws operates today, as it has historically, to play a significant role in states' control over its population. By regulating the movement of who is (not) eligible for entry, residence and citizenship in Canada, the government and bureaucracy have the political power and authority to define its population. This ability to define the criteria for potential citizens can be understood as a political operation of social control. Furthermore, not only is this ability an execution of social control, it also functions to define the ideal form of citizen, which in effect comprises the space available for discrimination and rejection of the failed applicant: a life rejected as unworthy for the regulatory goals of the state.

Citizenship and immigration policy and discourse in Canada continue to operate as a strategy that constructs a politics of inclusion (through a *productive* discourse) and exclusion (through a repressive discourse), with the contemporary emphasis being on the *productive* discourse. By evaluating technologies of immigrant medical examinations and attempts to liberalize and humanitarianize immigration and border technologies, this paper presents the case of Canadian medical diagnostics, which uncover both novel and old-fashioned mechanisms for state control over a population. Rather than being a case of either Canadian humanitarianism or ruptures to supposed humanitarianism, the case juxtaposes the Janus-faced character of modern immigration and border technologies.

Canadian citizenship and immigration policy and discourse appears in Acts, Regulations, policies and practices that affect who is allowed into Canada; this ultimately defines who will possess the rights necessary to participate as a political being. Discourse, in this article, refers to institutionalized thinking and speech, which depict social boundaries defining what is acceptable about a particular subject. As Judith Butler explains, discourse can be understood as the power to establish and maintain the domain of what will be publicly speakable. In addition to playing a limiting function to what is speakable, the state actively produces the domain of publicly speakable speech, demarcating the line between the domains of the speakable and the unspeakable and retaining the power. Butler refers to this as the ability 'to make and sustain that consequential line of demarcation' (Butler 1997: 356). Discourse, as both a limit and productive structure, delivers vocabulary, expressions and style necessary to communicate. Through historically constructed discourses, we can understand the plurality of truth and knowledge. These systems of thought construct subjects and produce meanings for identity and subjectivity.

In this paper, I respond to the following questions: if some citizens are desired, what of the non-desirable? How are these citizens defined? How do legal changes to the terms of acceptance for new immigrants – which provide a more productive context – repeat historical assumptions about (un)desirable citizens? I take up these questions to look at the (im)mobility of the Canadian border as it seeks to separate lives into categories of social worth and those lacking in worth. Precisely, I focus on the *health* and *wellness* of the Canadian population at large as the discursive context for a politics of inclusion and exclusion. This paper evaluates this dichotomization of life at our Canadian border using Foucauldian themes of 'biopolitics' and 'governmentality' to evaluate the interplay of immigrant medical examinations and an allegiance to Canadian humanitarianism, which refers to a commitment to principles of tolerance and inclusivity.

## Biology and Borders

Immigration and citizenship technologies in Canada separate qualified and worthy citizens from unqualified, unworthy lives. Not only does the state divide its population into citizens and foreign nationals, but the state also divides people into dichotomous categories of the healthy and the sick. As Susan Sontag states in *Illness as Metaphor*: 'illness is the night-side of life, a more onerous citizenship. Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick' (Sontag 1997: 47-48). Sontag discusses how the metaphor of illness operates to formulate a certain (mis)perception about people. She evaluates two diseases in particular, tuberculosis (TB) and cancer and

the stigmas that are associated with these illnesses. Her research illuminates the myth about these diseases and how this myth places the onus of responsibility for one's health on the individual rather than society or the state (Sontag 1997). Illness is depicted as a negation of self-responsibility and a negative consequence resulting from reckless self-conduct. These expectations for citizens to be responsible for their health appear in contemporary public health policy, discourse and practice. Consequently, these health-related expectations, both repressive and productive, motivate justifications for exclusion or inclusion into the Canadian state.

Public health policies as well as citizenship and immigration law, policy and practice have historically and continue today to operate as spatial forms of exclusion, integral to forming the Canadian nation. Since the end of the 19<sup>th</sup> Century in Canada, these racialized technologies aimed at the metaphorical and literal separation of 'citizen' from 'foreigner', 'clean' from 'unclean' and 'self' from 'other' (Mawani 2003: 4). In a quest to evaluate the meaning a healthy citizenry, I discuss medical diagnostics at the border. While contemporary health screening of migrants reflects historical exclusionary practices, current policy and discursive directions focus on how to use these exclusionary technologies for *inclusive* and *productive* population-health based strategies. The final section of this article evaluates this re-conceptualization of inclusive and productive population management at the border.

Despite the movement and flows of globalization, immigration technologies remain an area where the nation-state continues to exercise sovereignty through the selection and control of who enters and exits the country. With globalization, the best immigrants are desirable. These immigrants are those who can enhance Canada's competitive position in a world economy. According to contemporary political discourse, modern state-practices, which include policy and legislative changes, have shifted from overt racism and discrimination to become humanitarian and liberal over the last few decades. Although the contemporary technologies of immigrant evaluation are more liberal, policies and practices remain in place with the foundational assumptions from a historical discriminatory era.

## **Historical Review of Canadian Immigration Legislation**

Early immigration policy explicitly expressed a distinction between (un)desirable Canadian citizens. These sentiments were clearly put by one immigration superintendent that immigrants to be sought after were 'men of good muscle who are willing to hustle' (Knowles 2007). Jurisdiction over immigration and agriculture combined in Canada was set out in section 95 of the British North America Act (BNA Act), now the Constitution Act of 1867. This Act gave joint responsibility to both the federal and provincial government, with federal paramountcy for immigration. In 1869 the Canadian parliament passed the first act specifically dealing with immigration. It wasn't until 1872 when the act was amended to prohibit the entry of other vicious classes into the country and finally in 1879 an order-in-council was passed to exclude paupers and destitute immigrants from entering (Knowles 2007). The Department of Agriculture was responsible for immigration in the late 1800s, demonstrating a strong link to a particular kind of desired migrant. Specific categories of the 'desirable' were outlined, excluding those of 'sedentary' occupation, including mechanics, artisans and tradesmen (Knowles 2007: 71). The most desirable migrants were those that could directly produce for the nation and contribute to its economic prosperity.

Good agricultural settlers were historically the most desired citizens in Canada. Clifford Sifton, Minister of the Interior in 1896 outlined the desired citizen. This citizen is 'a stalwart peasant in a sheepskin coat born to the soil, whose forefathers have been farmers for ten generations, with a stout wife and a half-dozen children.' (Knowles 2007: 91-92). In the early 1900s, many Canadians already living in Canada were distrustful of the new immigrants who they perceived as taking away jobs. James Wilks, vice-president of the Trades and Labour Congress wrote Prime Minister Laurier, requesting that the government enforce the Alien Labour Act to prevent Canada from being inundated with ignorant and unfortunate aliens (Knowles 2007). This fear depicts the social climate when the 1906 Immigration Act was introduced. This Act outlined the undesirable category further to include prostitutes, the mentally

retarded, epileptic, insane, afflicted with contagious disease and any individual who was deaf, dumb, blind or infirm unless belonging to a family accompanying him or already in Canada (Knowles 2007). In 1910, Parliament gave the cabinet self-imposed power to sift through desirable candidates for citizenship. Cabinet had unlimited discretionary powers to issue orders-in-council to regulate the volume, ethnic origin or occupational composition of immigrants destined for Canada (Knowles 2007). This legislation gave the Immigration Branch tools to include immigrants into Canadian society as it deemed necessary.

In the post World War era, the Liberal government introduced the points-system, with formalization in 1967. Signaling the government's intent to link immigration closer to the labour market, Prime Minister Pearson said:

Immigration policy must be administered in the interests of the country and of the immigrants themselves in a context that takes into account the entire position of employment, training and placement in Canada. The association of various aspects of manpower policies under the same minister should make it easier to implement programs and to implement them more effectively (Knowles 2007).

The points system, which remains today, assesses all immigrants along skills and education criteria. It was formally introduced in 1976 with a new Immigration Act, which introduced three categories of migrants: independent, refugees and family class. Only independent immigrants are evaluated according to the points-system. Prior to the points-system, immigration officers made their determinations based primarily on level of education (Knowles 2007). Its system functioned as one avenue to streamline the process and make it more objective, fair and egalitarian. However, although this new points system depicts the importance of bringing the most *productive* citizens to Canada, discretion and more implicit forms of discrimination prevail in the contemporary context.

The intent of our current Canadian citizenship and immigration regime is outlined in the 2001 Immigration and Refugee Protection Act. The first goals appear to line up with the nice, hospitable or gentle Canadian humanitarian objectives such as pursuing maximum social, cultural and economic benefits of immigration and enriching the social and cultural fabric of Canadian society. These goals are outlined along the government's intent to further the domestic and international interests of Canada. Specifically, the objectives of Canada's citizenship and immigration program include:

- 3 (1) The objectives of this Act with respect to immigration are
  - (a) to permit Canada to pursue the maximum social, cultural and economic benefits of immigration;
  - (b) to enrich and strengthen the social and cultural fabric of Canadian society, while respecting the federal, bilingual and multicultural character of Canada;
  - (c) to support the development of a strong and prosperous Canadian economy, in which the benefits of immigration are shared across all regions of Canada;
  - (d) to see that families are reunited in Canada
  - (h) to protect the health and safety of Canadians and to maintain the security of Canadian society;
  - (i) to promote international justice and security by fostering respect for human rights and by denying access to Canadian territory to persons who are criminals or security risks [...] (Immigration and Refugee Protection Act, 2001: online).

This clause depicts the productive, inclusive language of a socially conscious immigration program; however, it appears within the context of a language that refers to economic necessity, essential for the productivity, sustainability and health of the Canadian population.

Language such as 'skills' and 'economic benefit' forms the crux of Canadian immigration policy. The points system evaluates independent immigrants who are not covered by the family or refugee class and

designates points for education, vocational training, occupation and work experience. An applicant must achieve approximately 67 out of 100 points possible (CIC 2006: online). The immigration system functions with the tenets of the liberal modern state. It assumes that the skills of applicants, which comprise their entire worth as potential Canadians, are mathematically measurable (Abu-Laban 1998). The points system places immigration within labour market requirements and business interests. Despite the goal to remove the racial and hierarchical language with the introduction of the points system in 1967, immigration technologies continue to operate within the paradigm of preexisting exclusive assumptions about migrants.

Contemporary immigration technologies demonstrate the state's emphasis on economic productivity as essential for potential citizens. In effect, the state imposes assumptions and expectations about productivity on outsiders attempting to gain access inside the state. As the state demarcates between the insiders and the outsiders, valued beings and non-valued beings, these exclusions reveal some assumptions about a qualified form of citizen and further, a qualified form of existence. As Aristotle articulates, we become political by entering into associations, in effect, we become political by becoming citizens. We come into associations for the sake of *life itself* (Aristotle 1962). If as Aristotle suggests, that being political requires citizenship, then it is imperative to question what kind of political form and space is excluded from the category of the citizen. Evidently, some forms of exclusion and discrimination remain embedded within the sovereign goals of the state. The next section of this article looks at the process of medical examinations as an assemblage of governmental technologies which operate to (re)produce processes of inclusion and exclusion as the state manages life in an attempt to screen worthy citizens.

### **Biological Screening in Canada: Historical Context**

One of the earliest depictions of exclusion based on health grounds appears in the case of D'Arcy Island and the relegation of Chinese lepers to this colony of the coast of BC. In the late 19<sup>th</sup> and early 20<sup>th</sup> centuries, leprosy was considered a serious public health concern, especially on the Canadian West Coast. Medical practitioners and government officials in countries including Canada and the United States stigmatized leprosy as a 'foreign' disease. Many believed that this disease originated in the warmer tropic climates and invaded and infected civilized nations through the bodies of dirty and diseased immigrants (Mawani 2003: 7). As Mawani argues, theories about the origins of leprosy were deeply embedded within the province's potent climate of anti-Chinese racism (Mawani 2003: 8). Consequently, explanations regarding the origins of leprosy in BC were often bound up with fears about unrestricted and unregulated Chinese immigration. Leprosy and Chinese immigration were seen as growing threats to BC's 'newly conceived imperial space' (Mawani 2003: 8). In this context of fear, state authorities and medical practitioners argued that leprosy was not indigenous to the region but imported to the settlement colony through the bodies of undesirable foreigners. Furthermore, leprosy was thought almost exclusively to be a Chinese disease.

These public health anxieties stimulated discussions about racial segregation and the need to contain Chinese immigrants in the province and prevent a further influx of aliens. To depict repressive, racist sentiment at the time, Mawani quotes the *Times Colonist*, 1899:

These lepers [in Victoria] are all Chinamen. If the people of British Columbia had their own way, Chinamen would be excluded from the provinces, but the Dominion government will not allow exclusion...strict provision should be taken to prevent any more lepers arriving in Canada. Every Chinaman should be obliged to pass a medical examination before being allowed to land in this country (in Mawani 2003: 9).

This article reiterates public opinion in the late 19<sup>th</sup> Century and the stigma of leprosy being a 'Chinese disease'. This (mis)perception appeared in national immigration and border strategies. These racialized conceptions have severe material consequences, which legitimized and reinforced more rigorous medical

inspections of Chinese immigrants as well as immigrants in general, within and external to the Canadian border. Efforts to control and prevent leprosy in Canada were inseparable from border control policies and practices.

Border policies have been tied to biology since confederation. Canadian history is laden with misperceptions about ill health, social inadequacy and racial discrimination. McLaren demonstrates in *Our Own Master Race* that we, as Canadians, happily imagine that our country was spared virulent racism and class-consciousness prevalent in the United States; however, Canada was not immune to eugenic preoccupations (McLaren 1990). Such preoccupations in the first half of the 20<sup>th</sup> century coloured the discussion of a vast variety of topics ranging from sex instruction, intelligence testing and special education to social welfare, immigration and birth control. McLaren's study illustrates the variety of ways in which assumptions about heredity were historically manifested. He provides biographical accounts of the different Canadian 'experts' drawn to eugenics, such as the public health pioneer Helen MacMurchy and geneticist Madge Thurlow Macklin.

In Canada, the primary support for eugenics came from those who believed that an understanding of heredity could improve public health. The most vocal defenders of eugenics were easily located within the medical profession. Doctors were paramount in ensuring that medical sciences could provide more efficient social management. McLaren articulates that throughout the Western world, the early 20<sup>th</sup> century witnessed the triumph of the medical authority and a corresponding rise in the social and political power of the doctor (McLaren 1990). Many medical professionals at the beginning of the 20<sup>th</sup> century were preoccupied with the physical and mental fitness of the Canadian population.

Although the federal Department of Health was established in 1919, the government had relied on the medical profession in administering its immigration legislation for decades. Eugenics-minded doctors in the early 20<sup>th</sup> century therefore had real expectations that their lobbying for tougher immigration restrictions reflecting hereditarian concerns would meet with some success (McLaren 1990). Doctors played a key role in employing eugenic arguments in the immigration debate. Leading medical journals continually expressed a belief that real hereditarian differences could not be overcome by an improvement of the environment. Dr. Charles Hastings, a medical health officer of Toronto asserted that Canada was committing 'race suicide' by sacrificing the well-being of its own youth to bring in newcomers. In the *Canadian Journal of Medicine and Surgery* (CJMS), he informed readers that it cost the federal government:

[...] nearly three quarters of a million annually for immigration purposes alone. Thousands are being imported annually of Russians, Finns, Italians, Hungarians, Belgians, Scandinavians, etc. The lives and environments of a large number of these have, no doubt, been such as is well calculated to breed degenerates. Who would think of comparing for a moment, in the interests of our country, mentally, morally, physically or commercially, a thousand of these foreigners with a thousand of Canadian birth (in McLaren 1990: 50).

This type of discrimination was rampant in Canada. In 1909, the CJMS asserted that Canada had become the 'garbage pail of England, Ireland and Scotland' (in McLaren 1990: 50). In an attempt to prevent these invalids from coming to Canada, professional doctors asserted that only specialists could determine the need for more sophisticated medical examination and mental testing. A significant contribution to the anti-immigration agitation was in this ability to specify the mental defectiveness of immigrants. It was a common belief that nations had the right to prevent themselves from being swamped by carriers of hereditary feeble-mindedness (McLaren 1990). Helen MacMurchy, the nation's expert on the subject, argued that these degenerates threatened the fabric of Canadian society. She argued that the feeble-minded should be barred from the country, necessitating medical inspections for immigrants.

Medical inspections were a way to keep the degenerates out. It was a common (mis)perception that foreigners were detrimental to the health of the nation. The aliens were, in the words of the American

eugenicist Prescott F. Hall, sterilizing their hosts (McLaren, 1990). In 1918, the Canadian National Committee for Mental Hygiene was established by C. K. Clarke and Clarence Hincks to draw attention to the fact that both the native and immigrant populations would have to be tested if their true potential was to be determined. The committee asserted that their surveys proved a direct correlation between immigration and insanity, criminality and unemployment (McLaren, 1990). Finally, in 1928, obligatory overseas medical examinations appeared as a requirement for Canadian citizenship as part of an attempt by the Mackenzie King government to ease the tide of fervent anti-immigration sentiment.

As Angus McLaren articulates, the chief success of Canada's past hereditarians did not consist of seriously impeding the entry of immigrants to Canada or defending Anglo-Saxon dominance; it lay in popularizing biological arguments to perpetuate the argument – so beloved by the anxious – that the nation's problems were largely the product of the outsider. While overt discrimination based on physical and mental health no longer formally exists in the 2001 Immigration and Refugee Protection Act, the next section of this article shows how processes of exclusionary tactics prevail through more implicit discursive techniques, couched in a language of productivity.

### **Qualifying Citizenship: Contemporary Canadian Medical Diagnostics**

In our present legislative environment, according to the Immigration and Refugee Protection Act and the corresponding regulations, all prospective permanent residents to Canada and certain temporary residents must undergo a medical examination. While only about 2,000 visa applicants are rejected on health grounds alone in Canada per year, it is important to note that all potential citizens must go through this medical examination as a requirement for citizenship.<sup>1</sup> It is crucial to consider the Canadian government's expectation that citizens must be responsible for their physical and mental health in order to be accepted as valuable individuals of worth to the Canadian society, able to contribute to a productive market economy. Of further note, we must also consider the goals of state-based medical examinations. For example, these diagnostics are currently a (repressive) method used to screen out potential citizens; however, new policy directions suggest momentum towards using these examinations as productive (or inclusive) intake procedures to collect data on newcomers to Canada.

The medical examination is conducted by a Designated Medical Practitioner (DMP), who is a physician selected by CIC (Citizenship & Immigration Canada) to do Immigrant Medical Exams (IME) on behalf of the government. The IME itself comprises the history, physical examination, mental examination and various routine tests depending on age.<sup>2</sup> The IME is done both overseas and on Canadian soil. Individuals already in Canada who wish to become Canadian citizens such as refugee claimants, students or temporary workers, will go through the IME in Canada. There are approximately 1,200 DMPs across the world. The results of the IME are sent to one of CIC's regional medical offices; there is one in Ottawa and there are nine overseas. A Medical Officer will conduct an Immigration Medical Assessment (IMA), review the DMPs examination and essentially make an opinion on admissibility or inadmissibility of an applicant based on health grounds. The results are sent to visa officers who make a final decision in terms of admissibility to Canada, based on their own discretion and interpretation of the applicable legislation.

The health-related admissibility criteria refer to: public health, public safety, and excessive demand, in addition to whether the person should require medical surveillance.<sup>3</sup> Some residents with certain illnesses must undergo surveillance as a condition of their acceptance. These include inactive TB (those who have

---

<sup>1</sup> Interview with Public Official, Health Management Branch, Citizenship and Immigration Canada, September 27th, 2007.

<sup>2</sup> Ibid.

<sup>3</sup> S. 38 of the Act reads:

38 (1) A foreign national is inadmissible on health grounds if their health condition:

- (a) is likely to be a danger to public health
- (b) is likely to be a danger to public safety; or
- (c) might reasonably be expected to cause excessive demand on health or social services.

active TB are rejected) and treated or positive syphilis (Overseas Processing Policy Manual). Anybody who has TB is refused entry to Canada. According to CIC Public Officials, the top priority for the medical examination is to protect public health and second, to evaluate excessive demand. A key concept underlying the examination is the goal of keeping out TB. As stated by a CIC official: 'The purpose of the IME for me personally, is to prevent entry of TB, number one, into Canada'.<sup>4</sup> Furthermore, not only are immigrants evaluated on pre-existing health conditions, but they are also screened for their potential to become unhealthy. This stigmatizes foreigners as prone to illness and plays on a common fear that foreigners bring diseases to 'our' Canadian nation.

Policy-makers define public health in contrast to public safety. As articulated by policy experts at CIC, public safety reflects a concern with danger to an individual, such as someone coming to Canada with paranoid schizophrenia, with the intent to injure a Canadian; public health reflects a concern with conditions that are transmissible such as the outbreak of infectious disease.<sup>5</sup> In this respect, the category of health as a condition of citizenship reflects economic and security elements, which feature prominently throughout the entire citizenship and immigration program. Excessive demand is defined in the Immigration and Refugee Protection Act regulations.<sup>6</sup> The requirement that each newcomer, including students and permanent residents, must undergo a process of medical scrutiny upon entry to Canada, demonstrates several components of a neoliberal immigration program. This program demonstrates fear of immigrants as outsiders and potential health risks to Canadians. In light of the mandate to assess potential risk, a medical officer will abide by the according Regulations.<sup>7</sup>

A main public health-related security concern identified by public officials refers to any migrant with significant psychiatric concerns.<sup>8</sup> Should border officials think someone has arrived with the *potential* to have a psychotic episode, they can re-request a medical examination. Even though someone may have papers to enter Canada, if they show up at a border and demonstrate signs of infectious disease, officials can stop individuals from entering Canada and enforce quarantine. CIC's Health Management Branch will provide advice to officials on what to do with and where to send individuals.<sup>9</sup> Evidently, health regulations and border security are powerful narratives are enmeshed at the Canadian border.

CIC discourse demonstrates the connection between neoliberal market principles and proper health. In particular, section 38(c) of IRPA projects a concern that immigrants who are unhealthy would cause an economic burden to Canadians. Evidently, there is no place for ill immigrants who need long-term care in Canada. There is an assumption that they are less likely to be productive and contribute to the Canadian economy. In order to make sure that immigrants would not place a burden on the Canadian welfare system, they must go through a rigorous process of medical scrutiny. In addition to protecting public safety and public health, the Health Management Branch at CIC must ensure that policy objectives fit within the economic goals of the government. For example, the Minister of Citizenship and Immigration

---

<sup>4</sup> See Note 1

<sup>5</sup> See Note 1

<sup>6</sup> (a) a demand on health services or social services for which the anticipated costs would likely exceed average Canadian per capita health services and social services costs over a period of five consecutive years immediately following the most recent medical examination required by these Regulations, unless there is evidence that significant costs are likely to be incurred beyond that period, in which case the period is no more than 10 consecutive years; or  
(b) a demand on health services or social services that would add to existing waiting lists and would increase the rate of mortality and morbidity in Canada as a result of the denial or delay in the provision of those services to Canadian citizens or permanent residents.

<sup>7</sup> 31. Before concluding whether a foreign national's health condition is likely to be a danger to public health, an officer who is assessing the foreign national's health condition shall consider  
(a) any report made by a health practitioner or medical laboratory with respect to the foreign national;  
(b) the communicability of any disease that the foreign national is affected by or carries; and  
(c) the impact that the disease could have on other persons living in Canada.

<sup>8</sup> See Note 1

<sup>9</sup> See Note 1

frequently refers to the policy objective of welcoming more workers into the country.<sup>10</sup> In effect, policy drafters must also bear this goal in mind when creating policy guidelines.

Furthermore, it is important to note that the IME is not a medical intake procedure. As described by one frontline social worker: ‘The IME is nothing more than a mechanism to screen people out. There is no medical treatment or follow-up from the IME’.<sup>11</sup> As we can link the origins of IMEs to historical practices of quarantine, medical examinations for potential citizens are based on an exclusionary model. Brian Gushulak, researcher and former citizenship and immigration public official, states that the current Canadian and international legislative framework is specifically designed to exclude people.<sup>12</sup> Traditional medical approaches to dealing with the health of migrants remain intact today. Historically, migrant health has been based on the principles of protecting the recipient population through the policies of exclusion directed at the migrant or arriving traveler.

As Gushulak argues, similar exclusionary processes continue in a modern context through immigration medical screening and border control practices intended to reduce threats to public health or to mitigate potential impacts on healthcare services (Gushulak 2006). Medical examinations in Canada are primarily focused on the prevention of TB, a communicable disease, which demonstrates the medical relationship between concerned host population and migrant. According to both the frontline worker and Dr. Gushulak, the IMEs instead should be used for *inclusive* practices, as intake examinations linked to primary follow-up care with physicians upon arrival of newcomers to the host nation. In addition, they argue that DMPs could use the IMEs to provide information about health care in Canada, facilitate follow-up treatment and adhere to strategic, productive health management strategies more broadly. In an interview with Dr. Gushulak, he articulated the importance of asking how we can expand the focus of IMEs from an exclusionary lens to a broader context that would allow the process to be used not only for the required legal screening issues to determine who cannot come, but begin to benefit the arriving people; and, if possible, be used as a tool to help with the individual and population health on arrival (Gushulak 2008). To carry this out, a form of pre-departure screening would make health integration upon arrival for newcomers much smoother.

In this population-health paradigm, epidemiologically-based longitudinal studies could potentially track migrant records in centralized databases so that health providers would have more detailed and comprehensive information to assist their follow-up and continuous migrant care. Gushulak *et al.*, argue: ‘A population health-based approach considers the relationship between migration and health as progressive, interactive process influenced by temporal and local variables’ (Gushulak *et al.* 2008: 2). This approach would consider the unique health experience or context that migrants face, based on their place of origin and departure. It considers the spectrum of people’s health experiences to factor in ‘place’, which includes disease risks what kind of care has been available in the place of departure and ‘time’, specifically regarding when the individual left and what the conditions were like over a period of time. This population health-based approach differs from the traditional exclusionary, threat or risk based model of immigrant medical examination. However, despite the shift from exclusive to inclusive medical examinations, the state-centric assumptions about qualified life and expectations for responsible self-

---

<sup>10</sup> See Note 1

<sup>11</sup> Interview with a frontline social worker from the British Columbia Multicultural Services Society. February 20<sup>th</sup>, 2008. Vancouver B.C.

<sup>12</sup> Interview with Brian Gushulak, Consultant, former Director of Migration Health Services of the International Organization for Migration in Geneva and former Director General of the Medical Services Branch of Citizenship and Immigration Canada. Currently Mr. Gushulak is assigned to Citizenship and Immigration dealing with control frameworks for the Canadian immigration medical examination process. His research interests include migration health and population mobility, international disease control and the history of quarantine practices. Dr. Gushulak has published several articles on the science and practice of migration health. He has recently co-authored a textbook dealing with health and migration. He is the past Chair of both the International Centre for Migration and the Refugee and Migration Health Committee of the International Society for Travel Medicine. Phone interview, March 21<sup>st</sup>, 2008.

conduct associated with health remain; to be a citizen requires good health in compliance with the productive goals of the state.

Should someone be ill, or should their condition place a burden on society, our state assumes that they would not be able to contribute to Canadian society. The excessive demand category leaves open the space for rejection based on disability, such as deafness, blindness or mental illness; these forms of disability would indeed place a 'demand on health and social services' and could legally be rejected. In light of the rejection of someone's residency claim based on a chronic condition, the state governs someone's life and determines its value. Consequently, the state dichotomizes life and formulates people into categories of healthy or unhealthy, accepted or rejected, valuable or worthless, insider or outsider. Given this process of inclusion and exclusion, the state makes a judgment over the value of life itself. Going further, not only does the state separate people into dichotomous categories of 'healthy/sick' but also current trends suggest a politicization of the health of the citizen proper.

Health discourse and affiliated medically diagnosed labels operate as powerful state technologies to regulate biological existence. The policy objectives mentioned in this article demonstrate a connection between market principles and health, which produce inequalities despite claims to a more liberal, open and less discriminatory legislative framework. There is an assumption that unhealthy migrants are less likely to be productive and contribute to the Canadian economy. This conceptualization of health, which forms the basis for medical diagnostics, can also be understood as an avenue for social power and control.

It is important to consider the social implications of biomedical diagnostic capabilities. As Nelkin and Tancredi articulate in *Dangerous Diagnostics*, assessments naturally have a futuristic quality, based on established institutional values (Nelkin and Tancredi 1989). Assessments are made, which categorize people in a commodified way. People, they argue, are not differentiated from machines. They are objects, reduced to examinable parts (Nelkin and Tancredi 1989). Human behaviour becomes explained through simplified, structured biological terms. Subjects with the potential to become ill are easily categorized and regulated in this medical regime. These tests, which define citizens as 'normal' (potentially acceptable) or 'abnormal' (unhealthy and potential risks), reinforce the social hierarchies embedded within our system with respect to degrees or classifications of health.

Health discourse and policy in this context is both repressive and productive. The discourse represses the unhealthy identity when excluding unhealthy immigrants from the Canadian community. Simultaneously, the health discourse is productive insofar as it produces a type of epidemiological knowledge and imposes this form of knowledge on foreign nationals. Consequently, health discourse and epidemiological knowledge shape and transform how citizens are perceived. Subjects (immigrants) become interpellated or upheld by these health categories (Poudrier 2003). Health discourse becomes a power tool of social control. Essentially, the fundamental producers of population health-based knowledge and information are the classifications of epidemiological science. However, health knowledge and the categories it produces are certainly not neutral or objective (Poudrier 2003). This has significance for our understanding of citizenship.

In our modern era, to be political necessitates citizenship and to be a citizen necessitates good health. In effect, to be worthy of citizenship, applicants must be healthy and productive members of society in the present and in the future. To this effect, medical examiners consider future health when evaluating potential risk. As a result, the citizen exists in a political condition where the potential risk of illness remains at the empirical and virtual border of the citizen's identity in Canada. This concept of potentiality recurs throughout the entire health and migration management program. The concern over potential harm, risk or threat, necessitates a governmental obsession with risk management strategies. These technologies can be understood through the political processes Michel Foucault and Nikolas Rose refer to in their discussion of governmentality, biopolitics and biopower.

## **Liberalism, Responsibility and Vital Politics**

The technologies of immigration and medical examinations in particular, demonstrate a type of political rationality and governance over life itself. This article argues that these technologies are closely linked with contemporary risk management practices, which have futuristic properties. These predictive futuristic qualities, which reflect a liberal rationality, brings the future into the present and subjectifies individuals or groups deemed to be 'risks' to the state.

Understanding this politics of vitality draws us back to where this article began with a conceptual map of biopolitics. In the *History of Sexuality*, Michel Foucault (1999: 143) states that: 'For millennia, man remained what he was for Aristotle, a living being with the additional capacity for political existence; modern man is an animal whose politics place his existence as a living being in question. Historically, sovereign power operated through the exercise of deciding life and death. In our modern era, contrary to sovereign power, a range of mechanisms operate to generate, incite, control, monitor and optimize individual and collective life (Rose 2007). Whereas wars of the past were carried out in the name of the sovereign, wars and border practices today are carried out in the name of protecting a population at large. Through governmental practices beyond sovereign power, life is managed in the name of the well-being of a population. As this article outlined in the introduction, biopolitical power according to Foucault operates in dual fashion: through the careful management of individual, disciplined bodies in order to maintain the rational efficient goals of the state and further, this power operates through a series of regulatory controls to manage the species body of the population as a whole. In this respect, biopolitical power operates as a 'bipolar technology' (Rose 2007: 53). The perspective of biopolitics highlights the operation of political power as a form of productive control and regulation of a population through rationalized technologies aimed at improving the vital capacity of the state.

In our contemporary neoliberal environment we witness a decline of the social elements of society. Our contemporary neoliberalism encourages autonomous, productive, self-sufficient citizens. The desirable immigrant is economically self-sufficient, productive and able-bodied in order to be as economically valuable to the state as possible. In our modern (neo)liberal society, political rationalities aim at both protecting populations at large and demanding individual responsibility in the name of broader population management. Nikolas Rose argues that the tension between individual and collective responsibility is now posed differently. It is no longer a question of seeking to classify, identify and eliminate or constrain those individuals bearing a defective constitution. In addition, it is not merely in question whether the reproduction of those whose biological characteristics are most desirable, in the name of the overall fitness, of the population, nature or race. Rather, contemporary political and social control operates through a variety of strategies that try to identify, treat, manage, or administer those individuals, groups or localities where risk is seen to be high (Rose 2007). The binary distinction between 'normal' and 'pathological' are now organized around strategies of risk. Risk strategies focus on epidemiological surveys of the population at large, as well as identifying and developing preventative strategies for populations identified to be 'at risk'.

Risk management technologies are not only negative and coercive but also productive. In addition helping the state regulate populations by classifying and filtering those seeking entry to Canada and searching out and removing the undesirables who get through, risk management technologies also construct identities and the meaning and value of a good citizen. These technologies are productive insofar as they bring in worthy individuals who will contribute to the states economy and vitality.

## **Conclusion**

This article argues that we can understand the Canadian border as a continuous *productive* design. By creating dividing technologies, state power operates to craft the make up of its population. Through a focus on historical changes to immigration, this article aimed to disrupt assumptions about liberal

immigration technologies that we take for granted. By historicizing immigration technologies, with an emphasis on biological regulation and the development of risk management strategies, I argue that a range of threats, dangers and uncertainties shape the Canadian border, which at once both (re)produces border security and is a byproduct of such anxiety and (in)security.

This article presented the case of immigration and specifically the assemblage of medical screening and examinations. Despite a new neoliberal quality of control, which includes progress towards inclusive population-health based technologies for newcomers, exclusionary, sovereign assumptions remain in tact at the Canadian border. Although explicit expressions of racism have formally been removed from immigration legislation, less visible and systemic forms of exclusions persist. Until the 1960s, racism intermingled with morality in the subjectification of (un)desirable citizens and (un)desirability linked discursively with the need to protect national purity. Today, although the subjectification of (un)desirable citizens is no longer explicitly presented in terms of protecting national purity, implicit forms of immigration technologies are attached to historical elements of explicit exclusions.

While a conventional reading of liberalized immigration technologies in the 1960s and 1970s supposedly marked the beginning of a new era, this reading focuses only on the overt claims in immigration legislation. This view, while focusing on the supposed nondiscriminatory dimensions of policy, glosses over the extensive use of discretion and implicit attempts to protect the population at large and to secure the economy and public health of the population as a whole through the creation and cultivation of healthy and productive citizens. While the way in which the technologies of discretion, border regulation and immigration practices are carried out take on new modes of operation, which can be understood through a liberal governmentality, these technologies also reify a form of historical state-centric protectionism, in effect, solidifying exclusive assumptions of the past in the spirit of a new inclusivity.

Future research about contemporary biopolitical management strategies, specifically with respect to biological surveillance and biological regulation, would certainly benefit from Rose's framework on vital politics and a new form of 'biological citizenship'. A (re)conceptualization of governmental power from this framework shows how bodies within states are included into the state for their productive and healthy capacity to contribute to broad health-based population management strategies. While the exclusionary tactics of immigrant border policies remain today – as changes are made in this field to become more inclusive and population-health based – revisiting the questions presented in this article will become crucial to our understanding of the complicated craft of a healthy polis in Canada.

## References

- Abu-Laban, Y. 1998. 'Keeping 'em Out'. *Painting the Maple*. Edited by Veronica Strong-Boag et. Al. Vancouver: UBC Press.
- Aristotle 1962. *The Politics*. Trans. By T.A. Sinclair. London: Penguin Classics.
- Butler, J. 1997. 'Sovereign Performatives in the Contemporary Scene of Utterance'. *Critical Inquiry*. Vol. 23(2) Winter.
- CIC [Citizenship & Immigration Canada]. 'How do I apply as a skilled worker?' *Immigrating to Canada*. [http://www.cic.gc.ca/english/faq/immigrating-5.html#5\\_1](http://www.cic.gc.ca/english/faq/immigrating-5.html#5_1) [last accessed 26 November 2006].
- Foucault, M. 1978. *History of Sexuality* Trans. by Robert Hurley. New York: Vintage Books.
- Foucault, M. 1994. in *The Essential Foucault* edited by Paul Rabinow and Nikolas Rose. New York: The New Press.
- Foucault, M. 1999. *History of Sexuality*, New York: Vintage Books.
- Gushulak, B. et al. 2006. 'The Basic Principles of Migration Health: Population Mobility and gaps in disease prevalence.' *Emerging Themes in Epidemiology*, May.
- Immigration and Refugee Protection Act 2001. <http://laws.justice.gc.ca> [last accessed 18 September 2008].
- Knowles, V. 2007. *Strangers At Our Gates: Canadian Immigration and Immigration Policy 1540-2006*. Toronto: Dundurn Press.
- Mawani, R. 2003. 'The Island of the Unclean: Race, Colonialism and Chinese Leprosy in BC 1891-1924'. *Law, Social Justice and Global Development*. (1).
- McLaren, A. 1990. *Our Own Master Race: Eugenics in Canada, 1885-1945*. Oxford: Oxford University Press.
- Nelkin, D. and Tancredi, L. 1989. *Dangerous Diagnostics: The Social Power of Biological Information*. New York: Basic Books.
- Overseas Processing Policy Manual 15. (Policy 10).

- Poudrier, J. 2003. In *Surveillance as Social Sorting*. Article 6. Edited by David Lyon.
- Pratt, A. 2005. *Detention and Deportation in Canada*. UBC Press: Vancouver.
- Rose, N. 2007. *The Politics of Life Itself*. Princeton: Princeton University Press.
- Sontag, S. 1977. *Illness as Metaphor*. New York: Picador Publishing.
- Wiebe, S. 2008. *Opinion*. 'Re-thinking Citizenship: (Un) Healthy Bodies and the Canadian Border'. *Surveillance and Society*. 5(3): 334-339, [http://www.surveillance-and-society.org/articles5\(3\)/opinion.pdf](http://www.surveillance-and-society.org/articles5(3)/opinion.pdf) [last accessed 18 September 2008].

### **Interviews**

- Interview with **Public Official**, Health Management Branch, Citizenship and Immigration Canada, September 27th, 2007. (4 interviews in total were conducted with current public officials in the field of public health and migration in Canada)
- Interview with a **frontline social worker** from the British Columbia Multicultural Services Society. February 20<sup>th</sup>, 2008. Vancouver B.C.
- Interview with **Brian Gushulak**, Consultant, former Director of Migration Health Services of the International Organization for Migration in Geneva and former Director General of the Medical Services Branch of Citizenship and Immigration Canada. Currently Mr. Gushulak is assigned to Citizenship and Immigration dealing with control frameworks for the Canadian immigration medical examination process. His research interests include migration health and population mobility, international disease control and the history of quarantine practices. Dr. Gushulak has published several articles on the science and practice of migration health. He has recently co-authored a textbook dealing with health and migration. He is the past Chair of both the International Centre for Migration and the Refugee and Migration Health Committee of the International Society for Travel Medicine. Phone interview, March 21<sup>st</sup>, 2008.