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Applicants for legal permanent residency in the United States are required to pass a medical screening. Most of these applicants are already living in the United States on non-immigrant and temporary visas and are screened by civil surgeons, physicians designated by the government to look for infectious diseases, incomplete immunization records, and signs that the immigrant will pose a threat or become a public charge. Little is known about the work of these 4000+ physicians, who play a key role as migration brokers in a context where migration control has devolved to non-state actors. I present quantitative analysis of a random survey of civil surgeons, identifying features of this migration industry and constructing at typology of profit seekers, immigrant advocates, and screeners. Most civil surgeons are in the private sector, dominated by immigrant doctors who tend to pass most applicants and charge higher fees. A smaller subset are in the public sector, dominated by US born doctors who pass fewer applicants and charge lower fees. These patterns exacerbate inequalities among immigrants. I consider theoretical implications for literatures on migration industries and brokerage, co-ethnic economies, and street-level bureaucrats, as well as the implications of the US case for global migration management.

Keywords: migration industry; civil surgeons; medical examination; co-ethnic economy; United States

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Over one million immigrants are granted permanent residency in the United States every year (US Department of Homeland Security 2016). All of these individuals are required to pass a medical screening conducted by a government-designated physician[1] who determines whether an immigrant applicant poses a threat to public health, appears likely to become a public charge, or presents a danger to property, safety, and welfare of self and others. Thousands of these designated physicians comprise a migration industry through which the neoliberal state outsources migration control (Cranston, Schapendonk, and Spaan 2017). Beyond the work of public health scholars concerned with the spread of specific diseases like tuberculosis, there has been very little research of contemporary medical screenings of immigrants as a facet of the migration regulation. Mandatory medical screenings are not unique to the United States. Immigrants to Canada are similarly screened by government-designated physicians, and medical screening of various kinds is required for immigrants to Australia, New Zealand, UK, Switzerland, and Israel, among others (Bisaillon 2010; Dara et al 2013; Keane and Gushalak 2001; Weibe 2009).

This paper seeks to fill the gap in the literature by presenting analysis of a random survey of civil surgeons. Civil surgeons[2] are physicians designated by the US government to conduct mandatory medical exams of people applying for legal permanent residency, specifically those who are attempting to adjust their status after already residing in the United States with temporary visas. In recent years, more than half of applicants are in this category: in 2014, 535,000 adjusted their status from other, non-permanent categories, compared to 481,000 who applied for legal permanent residency from abroad (US Department of Homeland Security 2016). Thus, civil surgeons are charged with screening hundreds of thousands of immigrant

applicants every year, all already living in the United States. State authority is delegated to these physicians by the US Citizenship and Immigration Service (USCIS), which ultimately makes the determination of eligibility, although it is the Center for Disease and Control Prevention (CDC), which sets the evolving and fuzzy medical criteria for exclusion. Mostly working in the private sector and profiting from these screenings, civil surgeons are an integral, if overlooked, part of the US migration system, shaping access to US residency in thousands of ordinary medical offices across the country.

Below, I present the first baseline picture of civil surgeons and their work, with a particular focus on their experience and training, motivations and challenges, type of medical practice, and conditions encountered. I investigate the factors affecting the rates with which different civil surgeons pass immigrant applicants that they screen – key question for access to legal permanent residency and the rights and opportunities that go with it. I frame the medical screenings of immigrants as constituting a migration industry, and I consider the role of medical screenings in reproducing inequities inherent in the US immigration system, as well as creating new inequalities.

Mandatory medical screening of immigrants

Immigrants have been and continue to be associated with disease and infection, in the United States and other countries of immigration (Fairchild 2003; Keane and Gushalak 2001; Kraut 2006, Markel and Stern 2002; Weibe 2009). In the course of the long history of immigrant medical screening, there are many examples of political rationales dominating epidemiological prerogatives and conflation of disease with deviance. When the United States began to screen and quarantine immigrants in the late 19th century, the agency in charge was the US Public

Health Service, a militarized cadre of physicians commanded by the Surgeon General. The US Public Health Service was instrumental in strengthening the association between immigration and danger, disease, and infection (Kraut 2006), which persists today. The early immigration exams, many conducted on Ellis Island, an entry inspection station through which most European immigrants passed at the turn of the 20th century, were touted by politicians as screening for immigrants who would pose a burden on society.

Contemporary medical screenings of immigrants no longer take place on militarized islands, but are rather in the hands of physicians acting on behalf of the state. Medical criteria for excludability has evolved over time and differs among receiving countries. After a period of exclusion and detainment of Haitian asylum seekers in Guantanamo, HIV/AIDS is no longer an inadmissible condition in the United States (Fairchild and Tynan 1994). Other countries, including Canada, continue to screen for HIV/ AIDS (Bisaillon 2010). In France, medical information can be used to determine eligibility for asylum (Fassin and d'Halluin 2005), although, unlike in the US, immigrants with serious illness that could not be treated in their home country cannot be deported there (Fisher 2013).

The mandatory medical screening of immigrants in the US is currently conducted by about 4000 civil surgeons, the individual screeners assigned to enforce the medical boundaries of the nation from within. (Applicants for legal permanent residency who apply from abroad are screened by the 400 panel physicians scattered across the world. "Panel physician" is a term for a government-designated physician located outside of the US.) Most physicians become civil surgeons by applying to USCIS for an official designation. They are eligible to apply after four years of experience as physicians. Those who work in state or county health department clinics can become civil surgeons through a blanket designation for the clinic. Civil surgeons are

unevenly distributed throughout the United States, with a profusion of options in some locations and long travel times needed to access screening professionals in others.

During the screening, civil surgeons review the applicant's medical history and medical records, and conduct a physical exam. They screen for communicable diseases of public health significance, currently including tuberculosis, syphilis and other sexually transmitted diseases, and Hansen's Disease (leprosy). The guidelines are developed by the CDC, and are periodically updated. Public health research indicates that many civil surgeons do not follow technical instructions from the CDC when detecting tuberculosis, with some not reporting or referring TB patients to the health department or starting treatment (Bemis et al 2016). This is evidence that the outsourcing of medical screenings to private physicians can further distance these screenings from public health prerogatives, such as limiting the spread of TB. Aside from being screened for communicable diseases, applicants have to have all required immunizations, including those that are not mandated of the general population (Canales 2009).

A 1994 report by panel physicians pointed to ethical dilemmas and conflicts between the goals of screening and the imperative to treat (Weekers and Siem 1997). There are multiple areas of potential tensions, including substance abuse and public charge portions of the screening. Government guidelines direct screening physicians to use the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders to define substance abuse and dependency. Yet, they are also required to report evidence of drug use as defined by the Controlled Substance Act, which creates a significant gray area with dire consequences for immigrants (Lakhani and Timmermans 2014). In addition, civil surgeons and panel physicians are charged with detecting physical and mental deviations that could result in the immigrant being a threat to people or property or a burden on the health system (CDC 1992). Medical

screening professionals make these assessments by assimilating medical uncertainty and scarcity of information and drawing stark lines between belonging and exclusion.

Although some immigrants are screened before applying for legal permanent residency – such as foreign students whose universities require proof of immunizations and refugees – many of the applicants are being screened for the first time. And many will have resided in the United States for long periods of time, during which they would have already had a chance to pose a threat with contagious diseases, mental and physical abnormalities, or addictions. The time gap between arrival and medical screening, as well as no medical screening for short term visitors are noted by public health scholars as inconsistent with sound public health policy in multiple countries (Dara et al 2013). Experts note that for this and other reasons, national programs of immigrant screenings tend to be "of limited public health relevance" (Keane and Gushalak 2001, 39). Analyses of medical screening of immigrants in different countries reveal tensions between public health, economic impacts, and human rights (Bisaillon 2010; Keane and Gushalak 2001; Weibe 2009).

The outcome of the screening is the completion of form I-693. On this form, civil surgeons indicate whether they have detected Class A or Class B conditions. Class A conditions make an applicant inadmissible. They include communicable diseases of public health significance; present or past physical or mental disorders associated with harmful behavior or disorders where harmful behavior is likely to happen again; and drug abuse or addiction. Class B conditions are physical or mental abnormalities, diseases, or disabilities that are serious or permanent enough that there is a 'substantial departure from normal well-being'. Crucially, civil surgeons do not get guidance on specific physical or mental conditions, aside from the communicable diseases, that may constitute threat to the 'property, safety, or welfare of

themselves or others' or departure from normal. A Class B condition may not make an applicant inadmissible, but it is serious enough to interfere with the immigrants' ability to care for themselves, go to school, or work, or it requires extensive medical treatment or institutionalization in the future. Upon reviewing the application, USCIS adjudicators may decide to reject the applicant who is determined to have a Class B condition. A failure to pass the screening has the potential to leave some immigrants in a setting – or deport them back to one – where appropriate medical care for either infectious or chronic disease is not available.

Medical screenings of immigrants can be a lucrative business for the physicians. Most recently, urgent care clinics have been entering the field of screening. USCIS does not set the fees that physicians charge immigrants for medical screening. A for-profit online service, easyIME (https://www.easyime.com/) allows applicants to compare fees of local civil surgeons that opt to be included in its database, serving as a middleman to make appointments. Among civil surgeons enrolled in easyIME, there is a wide variation in fees. For instance, an applicant living in Scranton, Pennsylvania would see 15 options from 1 to 68 miles away and ranging from $130 to $800. In a study of Los Angeles area immigration attorneys, Lakhani and Timmermans (2014) found that lower fees could be associated with civil surgeons who filled out forms incorrectly, then charged the fees again to correct them. They also report that some civil surgeons order unnecessary tests not even required on the forms (Lahkani and Timmermans 2014). Health insurance does not generally cover the full cost of these screenings. Access to health insurance and quality healthcare, however, can help in passing the medical screenings when applicants are able to provide documentation from their regular doctors or specialists that shows that their condition is being managed effectively or that they have a complete immunization record.

Lakhani and Timmermans (2014) is the only contemporary social scientific study of medical screenings of immigrants, and it presents research on immigration attorneys and their clients. This paper aims to provide the first direct portrait of the civil surgeons in the United States, their work and motivations. I explore factors related to differences among the civil surgeons in passing immigrants whom they screen, which illuminates their function as outsourced actors of migration regulation. For instance, I investigate differences in passing rates between civil surgeons in the private and public sectors, and between US born civil surgeons and those who are themselves immigrants.

Migration industries, brokerage, street-level bureaucrats, and ethnic enclaves

The devolution of immigration control and migration industries

In the context of neoliberal governance, migration regulation is outsourced to a variety of agents, just as every point of the migration process is now populated with formal and informal services and non-state actors (Hugo 1996). This devolution of immigration control – coupled with increased migration regulation – has been documented in Europe as well as in the US (Lahav 2000). Non-state actors are now involved not only in regulating the arrival of immigrants, but also the management of immigrant populations within countries. By outsourcing migration control and management, states benefit through reduction of costs and from being able to blame non-state actors for politically unpopular policies, such as cruel conditions of immigration detention (Lahav 2000).

Migration industries have become an inextricable part of migration management. The entities that compose migration industries, whether non-profit or for-profit, formal or informal, help regulate and facilitate migration. Analytical focus on migration industries allows migration

scholars to disaggregate and decenter the role of the state in understanding migration processes (Lahav 2000, Wimmer and Glick-Schiller 2002). At the same time, it highlights the labor that goes into migration management regardless of whether it takes place within a profit-making context (Cranston, Schapendonk, and Spaan 2017). Although most civil surgeons operate the medical screenings of immigrants as a business, even those in the non-profit sector are both regulating and facilitating migration. Like labor recruiters studied by McCollum and Findlay (2017), civil surgeons work both with and against the government as they conduct medical screenings of immigrants, driven by motives of profit, co-ethnic solidarity, and public health.

A related way of conceptualizing the work of civil surgeons is as migration brokers. Hernandez-Leon (2013) argues that the role of migration brokers is an undertheorized, yet crucial, component of the migration process. In considering civil surgeons more specifically as brokers between immigrants and state bureaucracies, it is useful to consider Faist's (2014) argument that the role of migration brokers is full of ambiguity, which is used by the state to 'bridge principles which cannot be reconciled on a practical level' (p. 43). Faist uses the example of tensions between migration control and social welfare in providing services for asylum seekers. Notably, sorting brokerage into for profit and non-profit categories belies the reality that profit motives and trust are not experienced by migrants themselves as contradictory, and that there are many similarities between how for profit and non-profit brokers operate (Lindquist, Biao and Yeoh 2012). When civil surgeons serve as brokers in the migration process, they not only reproduce existing inequalities, but have the potential to lay down new patterns of exclusion (Faist 2014).

Although it is common to conceptualise immigration into discreet chunks – before migration and after migration, or sending country and receiving country – there is analytical

leverage in understanding it as a process that is multi-sited, transnational, reversible, and characterised by asynchronicities. The emerging body of work on migration industries engages with this complexity, illuminating the ways in which various non-profit and for-profit entities comprising migration industries play a role in migration trajectories, even after migrants have arrived in the receiving country (Cranston, Schapendonk, and Spaan 2017; Garapich 2008). Kretsedemas (2012) highlights the rise of temporary immigration statuses as a key characteristic distinguishing the neoliberal migration system. The vicissitudes of the immigration process continue, often for many years, after the initial move with the intent to settle. Even as they live, work, and raise their families in the host country, immigrants are subject to migration controls, increasingly delegated to a multitude of non-state actors.

Street level bureaucracies

The work done by civil surgeons could also be understood as that of street-level bureaucrats (Lipsky 2010) operating on the frontlines of government policy in ways that often lead to a gap between policy and practice. As do other street-level bureaucrats, such as police officers or teachers, civil surgeons have some autonomy from government organizations – in this case USCIS and CDC – to make policy decisions on the ground. Maynard-Moody and Musheno (2003) show that these street-level bureaucrats judge who is worthy or unworthy of services based on such criteria as deference and perceived need.

Medical screening of immigrants is part of migration regulation. But its association with the medical profession and ostensible purview of public health belies its much broader scope and implications for the US migration system. Civil surgeons are gatekeepers of the nation, not only checking for complete vaccination records and testing for infectious disease, but making

decisions about what in the immigrant's body and medical record constitutes a threat to life and property and what may be evidence that the immigrant will pose a burden on the health care system. In doing so, they are likely judging the worthiness of their immigrant clients along other criteria, as well as drawing on their own membership in different social groups to selectively connect with some applicants (Maynard-Moody and Musheno 2003). Medical boundaries of the nation are built around ideas of deservingness, health, and burden (Viladrich 2012), and it is the routine work of civil surgeons to draw these boundaries.

Ethnic economies and healthcare providers

As I show below, many of the doctors who perform mandatory medical screenings of immigrants are themselves members of immigrant communities, which is a common feature of migration industries. As ethnic entrepreneurs, civil surgeons can benefit from social closure and trust within co-ethnic communities (Portes and Sensenbrenner 1993). Hernandez-Leon (2013) notes that in-group members capitalise on ethnic solidarities, commodifying them in order to make a profit through their participation in the migration management process. Co-ethnics are uniquely positioned to take advantage of profitable opportunities due to their connections to communities, specific knowledge of culture and immigrant context, and an understanding of host country's institutions. Co-ethnic migration brokers facilitate migration, as well as participate in its regulation and control. In many cases, their role encompasses a complex interweaving of both facilitation and control (Hernandez-Leon 2013).

Much of the literature on ethnic enclaves and ethnic economies is focused on the economic outcomes of immigrants who are employed by or find employment through their co-ethnics. Less has been written about immigrants as customers in the ethnic economy. One

notable exception is research on medical services provided by co-ethnics from the perspective of social determinants of health (e.g. Jang 2016). Lo and Bahar (2013) point out the complexity in the interactions between co-ethnic patients and healthcare workers, which are shaped by the embeddedness of the US healthcare within the class structure and its articulation with the immigration system. By considering how many civil surgeons play a part in ethnic economies, I bridge the research on ethnic economies and co-ethnic medical care.

Data and methods

This article presents analysis of an original random survey of civil surgeons in the United States. The sampling frame was obtained from the civil surgeons locator maintained by USCIS on its website (https://my.uscis.gov/findadoctor), resulting in around 4000 civil surgeons. I drew a random sample of 750 civil surgeons. In cases where one civil surgeon had multiple office locations, one location was chosen randomly. The survey was mailed to each civil surgeon in the sample in December of 2015, with a solicitation letter and a stamped, addressed envelope. A second copy of the survey was mailed to non-respondents in January of 2016. No monetary incentive was provided, but all participants were promised and received a report of the descriptive findings in May of 2016. Thirty-four surveys were returned for a variety of reasons, including wrong addresses, physician retirement from civil surgeon work, death, and, in one case, imprisonment for fraud. Out of the remaining 716 civil surgeons in the sample, there were 258 responses, with a response rate of 36 percent. Responses from the surveys were entered into an Excel spreadsheet by a research assistant, then checked by me against the original surveys and converted for analysis in STATA.

Physicians are a population known for low response to surveys, particularly those of more than a single page in length (McFarlane et al 2006). In fact, a 36 percent response rate exceeded my original expectations. Non-response bias appears to be less of an issue with physicians than with the general population (Kellerman and Herold 2001). Moreover, there is experimental evidence that unlike telephone surveys, mailed surveys can reduce non-response bias (Groves et al 2006). A comparison of geographic characteristics of those who returned completed surveys and the sample can be found in Table 1. It appears that there are no major differences between the state in which respondents work and the sample as a whole, with the exception of fewer than expected New York respondents.

<Insert Table 1 here>

The survey instrument was four pages long, with 19 questions in a booklet format. Early drafts of the survey were shared with a Massachusetts public health official and a civil surgeon in Colorado, and revised based on their feedback. Respondents were asked about their career history, particularly their designation as civil surgeon; their screening workload; types of conditions presenting; passing rates; fees charged; origins of those screened; and their own country of birth. Analysis indicates the robustness of the measures. For the key dependent variable in this paper, passing rates, there was a significant negative association with the number of excludable conditions found, as expected. There was also an association between working in a public clinic, having become a civil surgeon through blanket designation rather than individually, and charging lower fees, also as expected. To deal with missing data on the fee variable, a research assistant made phone calls to medical offices of respondents who left the fee question blank. We were able to fill in 19 missing responses. Key covariates in this paper included years of experience, screening more than 10 immigrants in the past month, typical fee amount,

working in a private practice, being US born, receiving civil surgeon training, reasons for becoming a civil surgeon, and challenges experienced in the work. As part of this project, I also conducted two semi-structured phone interviews with practicing civil surgeons. Each lasted about an hour, and provided additional information to contextualise the results.

Results and discussion

Civil surgeon characteristics and motivations

Civil surgeons responding to the survey were an experienced group, practicing medicine for an average of 26 years and serving as civil surgeons for 12. (See Table 2.) Most of the respondents (86 percent) were individually designated, which means they applied to USCIS to become civil surgeons as individual physicians, rather than through a blanket designation of an entire public health department.

<Insert Table 2 here>

Most respondents (79 percent) worked in a private practice. Thirteen percent reported working in urgent care clinics, with the rest of the respondents in federally qualified health centers, community health centers, rural health centers, and local health departments. As can be seen in Figure 1, the most important factor in becoming a civil surgeon appears to be serving a community with a large immigrant population: 64 percent of the respondents indicated that that was extremely or very important in their decision to become civil surgeons. For half of the respondents, having a patient panel with high immigrant population was an extremely or very important reason for seeking designation. Less common were seeking additional revenue and being asked by a medical director or boss.

<Insert Figure 1 here>

Medical screenings comprised a small fraction of most civil surgeons' practices. On average, respondents performed just 11 medical screenings of immigrants in the month prior to the survey, and almost half performed less than 6. A third performed between 10 and 30 screenings in the past month. An average of only 4.5 percent of their total patient workload was devoted to immigration screenings. The mean fees reported by the civil surgeon respondents are $238. It appears that most civil surgeons are not trained to conduct medical screenings of immigrants. Only 31 percent said that they have attended a training for civil surgeons held by USCIS or the health department. Even fewer – 22 percent – have attended a conference for civil surgeons. In fact, eleven respondents added comments on lack of adequate training and help, including one who referred to 'piss poor support'. Notably, respondents reported passing the vast majority of immigrants they screened. As Table 2 shows, 82 percent of the civil surgeons in the survey said that they passed all or mostly all immigrants they examined, 12 percent passed most, and no one in the survey passed less than half.

As seen in Table 3, civil surgeons screened immigrants from different regions. Those who commonly screened immigrants from Mexico and South and Central America were least likely to also commonly screen immigrants from other regions. For instance, there is only a week association (0.17, Pearson's chi square) between commonly screening Mexican and South and Central American immigrants and screening Asian immigrants. Such clustering by immigrant origin indicates that civil surgeons may specialise or operate within ethnic healthcare niches, although it is also possible co-ethnics select them based on proximity within immigrant neighborhoods. Many civil surgeons – 56 percent – were themselves born outside the United States.

<Insert Table 3 here>

Figure 2 presents a summary of responses about challenges faced by civil surgeons in performing immigration exams. The most commonly reported difficulty was incomplete or illegible or uninterpretable medical records. More than half of the respondents indicated that such records presented some kind of difficulty in screening immigrants. The burden of paperwork was also a significant difficulty, cited by close to half of the respondents as important. Among the more salient difficulties was an insufficient opportunity to determine condition, such as history of substance abuse. Less important were language barriers and deadline pressures from attorneys or patients. The least important difficulties were cultural and ethnic barriers and financial disincentives such as low or poor reimbursements.

<Insert Figure 2 here>

<Insert Table 4 here>

Table 4 presents bivariate associations between a range of civil surgeon characteristics and fees (one-sided two-sample t-tests) and passing rates (Pearson's chi square). Likely due to unaccounted factors, such as local variations in medical costs, the amount charged for immigration exams is not significantly associated with most other factors, with the exception of the type of practice. Not surprisingly, civil surgeons working in private practices and urgent care clinics charge higher fees for screening than those in public settings.

Passing rates and physician characteristics

There are statistically significant associations between a number of variables and civil surgeons' rates of passing immigrants they screen (Table 4). For instance, not many civil surgeons reported cultural barriers as an extremely or very important challenge, but those who did were significantly less likely to have the highest passing rates. In fact, the differences are striking:

only 33 percent of those extremely or very concerned with cultural/ethnic differences passed all or almost all of the applicants, compared to 84 percent for those who were less or not at all concerned. This indicates that some civil surgeons view immigrant applicants as significantly culturally different from themselves, and these same physicians view their work as part of migration enforcement, thus passing fewer applicants. The survey provided respondents with a space to note additional information important to know about their work, and 64 respondents did so. Two respondents commented on cultural and ethnic barriers they found difficult. A US born civil surgeon working in a Utah private practice wrote: 'Muslims refuse pelvic exam/exam to determine excludable conditions…I refer them to other USCIS providers.' And another US born civil surgeon working in an Illinois private practice indicated that 'males from certain cultures very hard on my female staff.'

On the other hand, civil surgeons who wanted to serve the community and those who were seeking additional revenue reported higher passing rates. 86 percent of those who said serving the community was extremely or very important in their decision to become civil surgeons passed almost all or all of applicants, compared to 75 percent of those who did not rate community highly. This could be evidence that community orientation among civil surgeons is at odds with screening prerogatives that would have resulted in higher rejection rates (for related research on police bureaucracies and immigrant populations, see Ramakrishnan and Lewis 2007). In other words, an interest in serving the community may go along with viewing one's role as someone who helps immigrants pass the medical screening, rather than serving as an agent of the state and guarding the boundary of the nation. Eighty-nine percent of those who are seeking additional revenue reported passing all or almost all applicants, compared to 78 percent among those who cared less about revenue. One explanation is that those especially interested in

immigration exams as a source of revenue did not want to acquire the reputation of rejecting many applicants.

US-born civil surgeons passed significantly fewer immigrant applicants. 77 percent reported passing all or almost all applicants, compared to 86 percent of foreign-born civil surgeons. While most civil surgeons pass most applicants, these are nevertheless significant patterns because hundreds of thousands of immigrants go through the screening process each year. Even a few percentage points translates to thousands of immigrants excluded from permanent residency. It appears that foreign-born civil surgeons, on average, may be less oriented towards the screening prerogatives of the process, and either view themselves as helping fellow immigrants and/or seeking to make a profit that is helped by high passing rates.

Several foreign-born physicians shed light on their decision to become civil surgeons. A British-born doctor with a private practice in California wrote: 'I got involved when a local CS [civil surgeon] overcharged me and provided no significant exam, and charged me over $500.' A Pakistani-born civil surgeon working in a public setting in Rhode Island explained: 'I feel good doing it as I myself was immigrant in past, know patient anxiety & expectations.' It is likely that the estimates of the differences between US born civil surgeons and those with immigrant backgrounds are conservative, as some US born civil surgeons may be children of immigrants. For instance, a Kansas-based civil surgeon with a private practice wrote: 'I was born in the USA but my family and I immigrated from Paraguay (which is why I enjoy doing these exams).'

Two US-born civil surgeons, one in private practice and the other at a public clinic, explained that they transitioned from other screening work, including conducting medical screening for the military, Federal Aviation Authority, and fire department. This indicates

another possible thread in the screening orientation of some civil surgeons who might view their immigration screenings similarly to screenings for employment.

I present results of multivariate analysis to further disentangle the patterns between passing rates and characteristics and motivations of civil surgeons. Table 5 shows the odds ratios of logistic regression predicting high passing rates. Model I considers the effects of characteristics of civil surgeons and their practice. Model II adds motivations to become civil surgeons. Model III adds challenges of being a civil surgeon.[3]

<Insert Table 5 here>

Results of multivariate analysis indicate a strong and consistent effect of civil surgeons' places of birth and screening loads on passing rates. In all models, being a US born civil surgeon is consistently associated with much lower passing rates. In Model III, being US born is associated with a 61 percent decline in odds of passing all or most applicants. Screening more than 10 applicants in the past month is also consistently associated with lower passing rates. In Model III, these higher screening loads were associated with a 66 percent decline in odds of passing all or most applicants.

There are no statistically significant effects on passing rates of the different reasons respondents reported for becoming a civil surgeon. Consistent with bivariate results, viewing cultural or ethnic barriers, which may limit physical examination, as a challenge was negatively associated with high passing rates, reducing the odds by 97 percent. As indicated in Table 5, models predicting the odds of highest passing rates are robust, and the inclusion of additional predictors increases explanatory power.

Type of practice and conditions encountered

There are significant differences in characteristics and responses of civil surgeons who worked in private practice or urgent care clinics some or all of the time, compared to those who only worked in public settings (see Table 6). One striking difference is the distribution of foreign-born civil surgeons: only 39 percent of those in private practice are US born, compared to 71 percent in public settings. Not surprisingly, those who work in public settings were less motivated by revenue and were much more often asked to become civil surgeons by supervisors. Civil surgeons in public settings appear to perceive more challenges, particularly in dealing with incomplete or illegible/uninterpretable medical records and paperwork burden. This could result from civil surgeons in public settings applying more scrutiny in screening and/or immigrant applicants presenting more complicated cases. Civil surgeons who are themselves immigrants dominate the private sector of immigration screening, and may have more experience with medical records from outside of the United States, or expectations of completeness and legibility that are shaped by their own experience outside of the United States.

<Insert Table 6 here>

Civil surgeons in private and public practice did report some significant differences in the types of conditions they encountered. Civil surgeons in public settings reported seeing more than twice as many Class B conditions: physical or mental abnormalities, diseases, or disabilities serious in degree or nature amounting to a substantial departure from well-being. They also saw significantly more physical or mental abnormalities, diseases, or disabilities that were not covered by the six other categories on the survey. Only Class A conditions are automatically inadmissible. Other conditions require adjudication by a USCIS officer – and civil surgeons receive only vague guidance in defining departures from the norm or threats to welfare. That civil surgeons in public settings are more likely to report encountering these types of conditions

may also indicate that they are more likely to look for them. This, in turn, may signal a different relationship to applicants and immigration exams. At the same time, this could be due to selection in the way applicants are distributed between public and private settings.

Ten respondents who added written comments questioned existing guidelines and procedures, or pointed out difficulties in performing their work. Civil surgeons complained about the complexity of the I-693 form and the challenge of keeping up with changing requirements, justifications for which are not provided. A few wanted to know why HIV was no longer on the list of excludable conditions, and pointed out that the current requirements are not always clinically relevant. A civil surgeon born in Eastern Europe and working in a Florida private practice doubted the validity of the screening itself:

> I often question the need for the examination; it increases the financial and paper load on immigrants and if they choose not to disclose information there is no verification. I specifically wonder about the usefulness of PPD testing for latent tuberculosis, when the patients who are diagnosed with it can then refuse therapy and the goal of [preventing] of contagious illness dissemination becomes undermined.

Relatedly, a US born civil surgeon with a private practice in Virginia noted that there is 'limited knowledge of patient to make accurate decisions, have to rely on patient self-reporting'.

Emerging typology of civil surgeons

Results of the survey show that civil surgeons are predominantly private sector actors. These private physicians charge higher fees for conducting the medical screenings, and have higher passing rates than those in the public sector. Although there are civil surgeons who rely more heavily on immigration exams in their practice, for most it appears to be a supplemental service.

Some may have applied to be designated as civil surgeons in order to provide this service when it is needed, but it does not comprise the core of the practice for most physicians. Those who went into the business of immigration exams to increase revenue tend to have higher passing rates, consistent with the profit motive. Failing immigrants is likely to get one a reputation that would put off new customers.

As is common in migration industries more generally (Hernandez-Leon 2013), there seems to be a strong co-ethnic element. Most civil surgeons are immigrants themselves, and immigrants dominate the private sector of the screening industry. Analysis indicates that many immigrant physicians in private practice screen applicants from the same regions of the world, and may even specialise in particular immigrant populations. Although more research is necessarily to fully explore the role of ethnic economics in medical screenings of immigrants, it appears that many civil surgeons are immigrant doctors who carve out ethnic niches as a business strategy. It is reasonable to suspect that these immigrant civil surgeons have an edge over US born civil surgeons in attracting and serving immigrants in their cultural or linguistic communities[4].

Most civil surgeons in the survey said that they were motivated to become civil surgeons in order to serve a community with a large immigrant population. That this motivation was associated with higher passing rates even when other factors were held constant indicates a possible weak orientation towards immigration enforcement through these screenings. Unlike the US-born dominated public sector, the immigrant-dominated private sector reported finding fewer of the vaguely-defined Class B conditions, which do not spell automatic exclusion for the applicant, and must be adjudicated by USCIS officers. Instead of migration enforcement, these civil surgeons may be working as migration facilitators, looking for ways to help immigrants

over this hurdle in the process, while also profiting from it. Assistance, profit, and even exploitation may all be intertwined in this private sector of the migration industry (Hernandez-Leon 2006; Lindquist, Biao and Yeoh 2012).

The findings are consistent with a rough typology of civil surgeons. Thus, in the private sector of this migration industry, there are the overlapping categories of profit seekers and advocates. *Profit seekers* may be interested in passing applicants to maintain reputation and attract additional customers, particularly those who are referred by immigration attorneys or other players in the competitive migration industry. They are likely to be found in private practice and urgent care clinics. *Immigrant advocates* are those who also have high passing rates but may see themselves as helping immigrants through a hurdle in the immigration system, perhaps one they are personally familiar with.

Disproportionately in the US-born physician-dominated public sector (e.g. public clinics), however, there is a third type of civil surgeon. *Screeners* may carry their orientation over from occupation-related screening, view their work as part of migration management and enforcement, or through a public health or healthcare system lens. Civil surgeons working in the public sector report lower passing rates and a significantly higher incidence of Class B and other conditions – conditions that do not automatically disqualify but place the applicant at risk of rejection by USCIS officers. Some of these civil surgeons identify cultural barriers as a challenge, which is associated with lower passing rates, even when controlling for other factors. Helping immigrants and making a profit are compatible but screening is less so, involving as it does a different and discordant role for the civil surgeon. Screening out anyone who may pose a health threat or be a public charge due to mental and physical abnormalities comes into tension

with seeing the applicants as customers to be satisfied or immigrants – perhaps fellow members of the ethnic community – to help through a difficult process.

Conclusions

The US government requires immigrants who are applying for legal permanent residency while already living in the US to undergo medical screenings. It delegates the work of screening hundreds of thousands of immigrants every year to thousands of physicians scattered across the country. These civil surgeons comprise a vast migration industry that facilitates migration and settlement while engaging in migration management and control. Yet, we know little of this migration industry or the way these medical gatekeepers shape migration control and migration processes. My analysis allows a glimpse into the system of immigration exams, and opens up avenues for future research.

The rough typology of civil surgeons that emerges in the analysis – profit-seekers, immigrant advocates, and screeners – suggests new mechanisms of stratification among the immigrant population. I show that most civil surgeons are immigrants themselves, and they are clustered among profit-seekers and immigrant advocates, who are more likely to pass applicants. Immigrant applicants who have access to ethnic economies and co-ethnic doctors due to their membership in an ethnic group have an advantage in passing their medical screenings. But if one does not live close to a co-ethnic cluster or an immigrant-rich community, the hurdle of the medical exam looms higher. The same is true for those who belong to a group that is scarce locally or one that may not have access to co-ethnic doctors.

Although the survey shows high passing rates, even a five percent failing rate translates to tens of thousands of people per year. Given the emerging typology of civil surgeons and the

corresponding differentiation within this migration industry between private and public sectors, it seems that immigrants face an unequal playing field. Immigrants with resources to retain an immigration attorney may be channeled to a civil surgeon – perhaps even a co-ethnic – who may charge unnecessarily high fees but can be relied on to get most applicants approved. Those with fewer resources or with weaker social networks may instead be screened in a public setting, where they will be charged less, but where they might be seen first and foremost as a potential threat to public health or a burden on the health care system and scrutinised accordingly. These immigrants are also less likely to have access to health care, making it more difficult to obtain forms and tests from their doctors – and to be healthy in the first place. Of course, there are those for whom the costs of the medical screening or the distance to the nearest available civil surgeon may be entirely prohibitive.

Many immigrants, particularly refugees, suffer mental illness connected to their past experiences, as well as their adjustment to a new country. Others experience physical and/or mental illness stemming from the poor working conditions they encounter in the US, widespread in the food production and construction sector (Kraut 2006), or as a consequence of racism and nativism. Medical screenings are yet another factor that makes the lives of immigrants on non-immigrant and temporary visas more precarious. At stake is access to legal permanent residency, a status with vastly expanded access to rights and opportunities than temporary non-immigrant statuses. Those who do not pass the medical screening can become undocumented and deportable.

Compared to some other players in the migration industry, such as private prison companies, most civil surgeons are only weakly engaged in migration enforcement. Their primary workload lies elsewhere, and they may be more focused on profit and helping

immigrants than on identifying immigrants who fail along the medical and public burden criteria. These physicians are also usually working without much training, support, or oversight, pointing to a gap between the migration enforcement prerogatives of the state and the interests of street-level bureaucrats. The exception may be the smaller subset of the industry that is run out of public clinics by mostly US-born physicians.

Lack of access to the US healthcare system intersects with mandatory medical screenings of immigrants to create additional layers of inequality. Having access to healthcare helps pass the screening. At the same time, the screenings themselves regulate access to healthcare when this access is predicated on immigration status. The 2010 Patient Protection and Affordable Care Act dramatically expanded healthcare provisions to US citizens and long-term immigrants, while excluding immigrants who are undocumented, on most temporary visas, or have been legal permanent residents for less than 5 years (Marrow and Joseph 2015). Medical screenings shape access to legal permanent status, which eventually leads to access to federally-subsidized healthcare. At the same time, legal permanent residents who use public healthcare provisions are at risk of being deemed public charges, and some have even been deported on medical grounds, particularly in cases where noncitizens would be accessing costly medical procedures (Park 2011, 2017). In 2018, the Trump administration proposed expanding what constitutes being a public charge for inadmissibility to permanent legal residency, including using subsidized health insurance and other non-cash programs, such as those for managing serious illness (Jewett et al 2018).

Mandatory medical screenings of immigrants are part of migration management systems in many countries across the globe (Bisaillon 2010. Dara et al 2013, Keane and Gushalak 2001, Weibe 2009). Although they differ in the details of their policies, these systems produce and

reproduce inequality by filtering access to rights and opportunities, often long after initial immigration. Migration regimes that reinforce global inequities and maintain the advantage of rich countries in postcolonial and neocolonial contexts have their rationales bolstered by the public health veneer of these screenings. This is the case even though real public health consequences of medical screenings of immigrants are dubious (Dara et al 2013; Keane and Gushalak 2001). The delegation of medical screenings to migration brokers allows the state to hand over the complex work of reconciling migration control and public health (Faist 2014).

Healthcare providers play an increasing role in migration management as immigration control devolves away from the state in many settings outside of the US (Lahav 2000; Wimmer and Glick-Schiller 2002). To better understand migration management, scholars have to direct their attention to the labor of those in migration industries, variably conceptualized as migration brokers, ethnic entrepreneurs, or street-level bureaucrats. In performing the work of screening immigrants within the context of migration industries, healthcare providers work both with and against the state (McCollum and Findlay 2017), although the balance of working with and against the state can change between private and public settings. My research shows that it is in the public settings that street-level bureaucrats may be most likely to view themselves as agents of the state, as they look to enforce migration policy through medical examinations. Yet within co-ethnic communities, profit motives, solidarity, and assistance may be difficult to disentangle in either the screening processes or the experience of migrants (Lindquist, Biao, and Yeoh 2012). Ethnic entrepreneurs benefit from social closure and trust within the ethnic community, even as they simultaneously facilitate migration and control it.

How close screening professionals are positioned vis-à-vis the state varies across migration and healthcare regimes. The US case is an instructive example of the way healthcare

professionals work as frontline screening workers. While particularly germane to migration enforcement, this screening work is an extension of other screening tasks healthcare professionals perform for the state, including conducting medical examinations tied to professional licensing (e.g. law enforcement, military, pilots, etc.) and adjudicating medical grounds for workers' compensation. In theorizing this work, we are well served by bridging the literatures on migration industries, street-level bureaucracies, and ethnic economies and solidarities, as I have tried to do here, because of the realities of state control devolution in multiethnic contexts with long histories of migration. The US is far from being unique in being a multiethnic society where immigrant communities themselves are implicated in outsourced migration control both as subjects and agents of the state. Research is especially needed in understanding immigrants as customers of co-ethnic entrepreneurs, such as co-ethnic healthcare workers.

Further work is necessary to investigate immigrant medical screenings and their role in migration regulation and control, as well as the experience of screening healthcare professionals and immigrants themselves. Due to the nature of the survey, it is not possible to analyze how healthcare workers viewed their work directly. While I believe that these results point convincingly to significant patterns of differentiation among the civil surgeons along critical dimensions, future qualitative research will contribute to a fuller picture of the medical screening process and the differences among civil surgeons in the US and their counterparts in other countries.

1. In the US, the term 'physician' refers to individuals with Doctor of Medicine (MD) degree and a license to practice medicine.

2. In the US, the term 'civil surgeon' does not refer to someone who practices surgery but strictly to physicians designated by the government to screen immigrants. Civil surgeons are more commonly referred to as "immigration doctors" or doctors who do "immigration exams".

3. Because of a moderate association between two of the reasons given for becoming a civil surgeon: having an immigrant-heavy patient panel and wanting to serve the community, I omit the former from the analysis. For the same reason, I omit deadlines from patients and attorneys as a challenge of doing civil surgeon work, which is associated with finding financial disincentives to be a challenge.

4. In applying to be designated as civil surgeons, physicians are asked an optional question about language spoken in their office, although the current USCIS civil surgeon locator does not show this information.

References

Bemis, Kelley, Andrew Thornton, Alfonso Rodriguez-Lainz, Phil Lowenthal, Miguel Escobedo et al. 2016. "Civil Surgeon Tuberculosis Evaluations for Foreign-Born Persons Seeking Permanent U.S. Residence." *Journal of Immigrant and Minority Health* 18(2): 301–307.

Bisaillon, Laura M. 2010. "Human Rights Consequences of Mandatory HIV Screening Policy of Newcomers to Canada." *Health and Human Rights in Practice* 12(2): 119-134.

Canales, Christie V. 2009. "HPV Vaccination Requirement for Female Immigrants: An Example of Discrimination." *Journal of Gender, Race & Justice* 13: 779.

Centers for Disease Control and Prevention. 1992 *Technical Instructions for Medical Examination of Aliens in the United States.* Department of Health and Human Services, http://www.cdc.gov/Ncidod/Dq/pdf/ti-civil.pdf.

Cranston, Sophie, Joris Schapendonk, and Ernst Spaan. 2017. "New Directions in Exploring the Migration Industries: Introduction to Special Issue." *Journal of Ethnic and Migration Studies* 44(4): 543-557.

Dara, Masoud, Brian D. Gushalak, Drew L. Posey, Jean-Pierre Zellweger, and Giovanni B. Migliori. 2013. "The History and Evolution of Immigration Medical Screening for Tuberculosis." *Expert Review of Anti-Infective Therapy* 11(2): 137-146.

Fairchild, Amy L. 2003. *Science at the Borders: Immigrant Medical Inspection and the Shaping of the Modern Industrial Labor Force*. Baltimore, MD: John Hopkins Press.

Fairchild, Amy L., and Eileen A. Tynan. 1994. "Policies of Containment: Immigration in the Era of AIDS." *American Journal of Public Health* 84(12): 2011–2022.

Faist, Thomas. 2014. "Brokerage in Cross-Border Mobility: Social Mechanisms and the (Re)Production of Social Inequalities." *Social Inclusion* 2(4): 38–52.

Fassin, Didier and Estelle d'Halluin. 2005. "The Truth from the Body: Medical Certificates as Ultimate Evidence for Asylum Seekers." *American Anthropologist* 107(4): 597–608.

Fisher, Nicolas. 2010. “Bodies at the Border: The Medical Protection of Immigrants in a French Immigration Detention Centre.” *Ethnic and Racial Studies* 36(7): 1162-1179.

Garapich, Michal P. 2008. “The Migration Industry and Civil Society: Polish Immigrants in the United Kingdom Before and After EU Enlargement.” *Journal of Ethnic and Migration Studies* 34(5): 735–52.

Groves, Robert M., Mick P. Couper, Stanley Presser, et al. 2006. “Experiments in Producing Nonresponse Bias.” *Public Opinion Quarterly* 70(5): 720–736.

Hernández León, Ruben. 2013. “Conceptualizing the Migration Industry.” In *The Migration Industry and the Commercialization of International Migration*, edited by T. Gammeltoft-Hansen and N. Nyberg Sorenson, 24–44. Oxford: Routledge.

Hugo, G. 1996. “Environmental Concerns and International Migration.” *International Migration Review* 30(1): 105–131.

Jang, Sou Hyun. 2016. "First-Generation Korean Immigrants’ Barriers to Healthcare and Their Coping Strategies in the US." *Social Science & Medicine* 168: 93-100.

Jewett, Christina, Melissa Bailey, Kaiser Health News, and Paula Andalo. “Under Trump Proposal, Lawful Immigrants Might Be Inclined To Shun Health Benefits.” Washington Post. May 11, 2018.

Keane, V.P. and B.D. Gushalak. 2001. “The Medical Assessment of Migrants: Current Limitations and Future Potential.” *International Migration* 39(2): 29-42.

Kellerman, Scott E., and Joan Herold. 2001. “Physician Response to Surveys.” *American Journal of Preventive Medicine* 20(1): 61–67.

Kraut, Alan M. 2006. “Bodies from Abroad: Immigration, Health, and Disease.” In *A Companion to American Immigration*. Reed Ueda, ed. Pp. 106–131. Oxford: Blackwell Publishing Ltd.

Kretsedemas, Philip. 2012. “The Limits of Control: Neo-Liberal Policy Priorities and The US Non-Immigrant Flow.” *International Migration* 50(s1): e1-e18.

Lahav, Gallya. 2010. “The Rise of Nonstate Actors in Migration Regulation in the United States and Europe: Changing the Gatekeepers or Bringing Back the State?” in *Immigration Research for a New Century: Multidisciplinary Perspectives*, edited by Nancy Foner, Rubén G. Rumbaut, Steven J. Gold, 215-241. New York: Russell Sage Foundation.

Lakhani, Sarah Morando, and Stefan Timmermans. 2014. “Biopolitical Citizenship in the Immigration Adjudication Process.” *Social Problems* 61(3): 360–379.

Lindquist, Johan, Biao Xiang, and Brenda Yeoh. 2012. “Opening The Black Box of Migration: Brokers, the Organization of Transnational Mobility and The Changing Political Economy in Asia.” *Pacific Affairs 85*(1): 7-19.

Lipsky, Michael. 2010. *Street-Level Bureaucracy: Dilemmas of the Individual in Public Services*. New York: Russell Sage.

Lo, Ming-Cheng Miriam, and Roxana Bahar. 2013. "Resisting the Colonization of the Lifeworld? Immigrant Patients' Experiences with Co-Ethnic Healthcare Workers." *Social Science & Medicine* 87: 68-76.

Markel, Howard and Alexandra Minna Stern. 2002. “The Foreignness of Germs: The Persistent Association of Immigrants and Disease in American Society.” *Milbank Quarterly* 80(4): 757-788

Marrow, Helen B., and Tiffany D. Joseph. 2015. “Excluded and Frozen Out: Unauthorised Immigrants’ (Non)Access to Care after US Health Care Reform.” *Journal of Ethnic and Migration Studies* 41(14): 2253–2273.

Maynard-Moody, Steven and Michael Musheno. 2003. *Cops, Teachers, Counselors: Stories from the Front Lines of Public Service*. Ann Arbor, Michigan: University of Michigan Press.

McCollum, David and Allan Findlay. 2017. “Oiling the Wheels? Flexible Labour Markets and the Migration Industry.” *Journal of Ethnic and Migration Studies* 44(4): 558-574.

McFarlane, Emily, Murrey G. Olmsted, Joe Murphy, and Craig A. Hill. 2007. “Nonresponse Bias in a Mail Survey of Physicians.” *Evaluation & the Health Professions* 30(2): 170–185.

Park, Lisa Sun-Hee. 2011. *Entitled to Nothing: The Struggle for Immigrant Health Care in the Age of Welfare Reform*. New York: New York University.

Park, Lisa Sun-Hee. 2017. “Medical Deportations: Blurring the Line between Health Care and Immigration Enforcement.” in *Immigration Policy in the Age of Punishment*, edited by David Brotherton and Philip Kretsedemas, 240-256. New York: Columbia University Press.

Portes, Alejandro, and Julia Sensenbrenner. 1993. "Embeddedness and Immigration: Notes on the Social Determinants of Economic Action.” *American Journal of Sociology* 98(6): 1320-50.

Ramakrishnan, S. Karthick and Paul Lewis. 2007. “Police Practices in Immigrant-Destination Cities.” Urban Affairs Review 42(6):874-900.

US Department of Homeland Security. 2016. Yearbook of Immigration Statistics: 2015. Washington, D.C.: U.S. Department of Homeland Security, Office of Immigration Statistics.

Viladrich, Anahí. 2012. “Beyond Welfare Reform: Reframing Undocumented Immigrants’ Entitlement to Health Care in the United States, a Critical Review.” *Social Science & Medicine* 74(6): 822–829.

Weekers, Jacqueline and Harald Siem. 1997. “Is Compulsory Overseas Screening of Migrants Justifiable?” *Public Health Reports* 112(5): 396–402.

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

Wimmer, Andreas, and Nina Glick-Schiller. 2002. “Methodological Nationalism and Beyond: Nation-State Building, Migration and the Social Sciences.” *Global Networks* 2(4): 301–334.