Creating a Culture of Care: Navigating the Politics of Life and Death in the Clinical Setting

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Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place. - Susan Sontag, Illness as Metaphor

In 1999, Nell Toussaint left her native home of Grenada for Canada. Overstaying her visa, she found work in a variety of temporary minimum-wage jobs which would support her for what would be nearly two decades. Living in Canada, she maintained precarious immigration status, all while working and subsequently contributing to Canada’s social security and tax systems through pay-roll deductions. Nell twice attempted to apply for permanent residency on the basis of compassionate and humanitarian grounds – on both occasions, her attempts were thwarted in part by her inability to finance her application. Soon thereafter, her health began to deteriorate.

As an irregular migrant, Nell was ineligible for public health insurance and lacked the financial resources necessary to access private healthcare services. On multiple occasions, she found herself in need of emergency medical care which required her to pay out-of-pocket – a crippling responsibility for a woman valiantly trying to make ends meet. As a result of her increasingly poor health, Nell was soon phased out of the labour market. Needing care now more than ever, Nell found herself unable to afford the services necessary to sustain her life. Turning to Canada’s Interim Federal Health Program (IFHP) for assistance, she was denied repeatedly, even after going so far as to challenge the decision at the Federal Court and Federal Court of Appeal.

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4 Ibid.
5 Ibid.
6 Kansal and Agarwal.
7 Ibid.
8 Ibid.
By 2009, much like her status, Nell’s likelihood of survival was precarious. Having been denied an ultrasound in a Toronto emergency room, the system failed to recognize and appropriately attend to a threatening blood clot in her leg. The inability of Canada’s healthcare system to address and contend with Nell’s ailment caused irreversible damage, impairing her vision, mobility and ability to speak. Finally, in 2013, Nell was granted permanent residency and became eligible for provincial insurance. Unfortunately, her mental and physical health had already been compromised.

Sadly, Nell’s case does not mark the exception, but rather the rule. Nell’s treatment tragically illustrates a reality all too familiar for irregular migrants whose lack of citizenship excludes them from critical healthcare services. With their refusal to treat, the Canadian healthcare system insinuates that the value placed upon a life is directly proportional to the legal status that that life enjoys. There is a tendency to publicize the Canadian healthcare system as “universal”, though it excludes many of those living within our borders. In Canada, the right to healthcare is a right conferred by citizenship, not by virtue of personhood. If illness knows no citizenship, then why does healthcare?

The topic that has inspired this project is whether the Canadian healthcare system politicizes issues of health and wellbeing as they concern irregular migrants, thereby confusing the logic of the professional practitioner to the detriment of human life. The purpose of this project is to investigate the manner by which the government implicitly utilizes healthcare providers to enforce discriminatory public policy. This project also aims to explore how healthcare providers understand their role as an individual capable of sustaining life and as a professional governed by ethical principles and legislation. Of interest is the inherent tension

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9 Ibid.
10 Ibid.
11 Ibid.
between ethical commitments, policy, and legislation. Here, I intend to make explicit the manner in which the government manipulates the capabilities of the provider in such a way that perpetuates political ideology at the cost of human life. Providers must make critically important decisions to treat which exist at the intersection of ethics and the law. These decisions implicate their patients who require their highly unique skill set to support their health and wellbeing and their sense of moral obligation - both of which may conflict with policy regulations. As such, my research seeks to answer the following questions: How might the Canadian healthcare system use the healthcare provider as a tool in preserving discriminatory public policy? How does this practice endanger both the provider’s ethical responsibilities and the life of the prospective patient?

I will argue that the complex relationship between providers and the law creates a culture of care wherein professionals are tasked with enacting discriminatory policies, therefore acting as political agents to the detriment of patient accessors. I put forward the idea that this politically driven culture of care operates at the social, mental, and physical expense of those patients who lack legal citizenship. I further assert that the role of these providers is confused, complicated and undermined as a result of this political manipulation. Policies which demarcate people on the basis of citizenship and utilize the healthcare system to support this stark hierarchical division have dangerous implications for human rights, morality, ethics and political power. In this sense, the clinical setting is one where therapeutic and bureaucratic power are in tension at the expense of providers and patients alike.

I will begin by detailing what it means to be without legal status, attempting to destigmatize commonly used terms as they are often associated with the designation of “illegal”. A brief literature review will follow where existing research will be detailed and explored. To
follow, I will make clear the relationship between public policy and political ideology, explicating healthcare policy as a political issue. Specifically, I will make reference to Ontario’s healthcare system, as Ontario is a popular destination for migrants. Exploring both the federal and provincial systems, I will conduct a review of the relevant legislation, policies and ethics that govern healthcare providers and accessors. Following this, I will attempt to make sense of the healthcare system, endeavouring to explicate the nuanced implications of such policies and their practical outputs. I will then detail the relevant ethical dilemmas encountered by healthcare professionals when working with irregular migrants, highlighting the challenges that the public policy poses to the delivery of care. To conclude, a final discussion will occur.

Rethinking the Term “Illegal” – What is Means to be Without Status

There is a socio-political inclination to label individuals without legal status ‘illegal’, a term imbued with epithets of criminality. There are many reasons why a person may be without status, most of which do not correspond with the narrative that often depicts these individuals as predatory characters evading legal border crossings in favour of smuggling operations and ‘backdoor’ entry points. The inclination to victimize the ‘outsider’ has astounding socio-political ramifications, manifesting within policy and legislation.

For the purpose of this paper, individual’s without legal status will be here forth termed “irregular migrants”. Irregular migration is the movement of persons as it takes place outside of the laws, regulations, or international agreements governing the entry into or exit from the state of origin, transit or destination. This term may also include individuals who have entered a country by way of law but fail to abide by the regulations placed upon their stay. I wish to encourage the use of this term as preferential to “illegal migrants”. It ought to be recognized that

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to enter and live within a country by way of irregular means is not a criminal offence, but an
infraction of administrative regulations.\textsuperscript{13} It is imperative to acknowledge that while an act may be legal or illegal, a person may not.\textsuperscript{14} Designating a person, or group of people as ‘illegal’ has a dehumanizing effect that contributes to a culture of hostility in which abject treatment of these communities is justified.

An irregular migrant may be a child whose family dissolution resulted in the loss of sponsorship, a pregnant woman who bears her child before she is able to secure her papers, or a failed refugee claimant who fears persecution or even death upon return to their country of origin. The process of obtaining Canadian permanent residency is long and precarious, with applicants all too often living within the margins of society, working menial and dangerous jobs in efforts to make ends meet. It is critical to understand that while these individuals have yet to be legally verified, most have been steadfast in their attempts at obtaining such validation.

\textbf{Literature Review}

The following discussion will explore the existing body of literature as it pertains to the current Canadian culture of care whereby life sustaining services and resources are subject to political governance thereby harming irregular migrants and providers. Upon investigation and assessment of the manner in which this concept has been understood within prevailing narratives, I will bring attention to the deficiencies within the current body of literature, suggesting the ways in which my research may fill these gaps.

\begin{footnotesize}
\textsuperscript{14} Ibid.
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The Stigmatization of Migrants

Repeatedly, new migrants are categorized as “deserving” or “undeserving”, with irregular migrants occupying the less preferable former.\textsuperscript{15} Those individuals shamefully placed within this stigmatized category are subsequently precluded from accessing vital social services.\textsuperscript{16} This unfair categorization perpetuates the marginalization of these populations who fall victim to further discrimination once labelled as such – thus generating a cycle of harm whereby they are excluded from social, political, economic and cultural life to the detriment of their health and wellbeing.\textsuperscript{17} Discussing the power of public discourse, Gottlieb and Ben Mocha investigate how the framing of irregular migration as destructive generates concerns that inform moral frameworks so to legitimize legal rights holders while invalidating the claims of irregular migrants.\textsuperscript{18} Policymakers frame issues of irregular migration in such a way that encourages hostility towards newcomers, putting forth arguments that play off of ‘resource scarcity’, ‘overstretched healthcare services’, and the infamous ‘expanding healthcare access encourages more illegal immigration’.\textsuperscript{19} Sadly, these unsavoury archetypes are downloaded into the collective consciousness which becomes complicit in acts of governmentally sanctioned exclusion.

Situating the Healthcare System & Locating the Clinic within the State

Situating the healthcare system as a social entity, Kivelä and Moisio assert that these systems are not politically neutral.\textsuperscript{20} Kivelä and Moisio claim that healthcare systems represent the institutionalization of geopolitics and biopolitics, demonstrating how healthcare functions as
a “statist” social practice.21 In this sense, and within this system, ‘life’ is necessarily connected to
the territorial organization of the state as politics are intertwined with access to healthcare
services.22 Conceptualizing a territory’s healthcare system as a materialization of state interests,
Kivelä and Moisio beautifully articulate the manner in which the more localized clinical setting
operates as a socio-political institution.23 Acting itself as a mode of governance, the clinic
contains a marriage of therapeutic and bureaucratic power, and as a result, is capable of
exercising this power over human life.24 With this power, the clinical setting operates as a site of
contention and negotiation of care and citizenship where the lives of the particularly vulnerable
hang in the balance.25 Miklavcic argues that by enacting practices of biopower and
governmentality, the clinic demarcates those lives that have value by virtue of state recognition
(e.g. citizens and permanent residents) from those that lack such value as a result of their
irregular migration status.26

The Clinic as a Site of Tension

Canadian systems demonstrably favour particular groups over others as they stratify
individuals on the basis of citizenship, prioritizing those that the country identifies as legally
valid.27 Calling attention to the integral contributions of migrants, Caulford and D’Andrade argue
that decisions to treat as based upon citizenship unfairly ignore the fact that most migrants
occupy a position in the labour force, therefore contributing to the very systems that they are
unable to access.28 Caulford and D’Andrade also bring attention to a particularly interesting

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21 Ibid.
22 Ibid.
23 Ibid, 41.
25 Ibid, 496.
26 Ibid, 497.
27 DeShalit, Edmonds and Sidhu, 69.
quagmire impacting irregular migrants, explaining that while it is these populations who typically work within the most dirty, difficult and dangerous workspaces, they are the small percentage of the population excluded from the public healthcare system.29 Caulford and D’Andrade argue that physicians have a professional responsibility to provide medically necessary care to all residents, regardless of their political status.30 Conducting ethnographic research in a Montreal mental health facility, Miklavcic found that physicians at this clinic operate under a “don’t ask, don’t tell” policy that encourages them to provide unconditional care to all patients regardless of status, choosing to prioritize their ethical obligations to their patients.31 In maintaining such a policy, these physicians attempt to circumvent relevant governmentally emplaced restrictions.32 Investigating the attitudes and perceptions of healthcare providers who find themselves responding to irregular migrants, Suphanchaimat et al. similarly found that providers frequently ‘ignored’ the legal status of accessors, again selecting to prioritize patient needs.33 The fact still remains, that practitioners often feel a tension between their professional ethics, laws, and migrants’ limited rights to healthcare, complicating the delivery of their services.34

Bridging the Gap

As evidenced, much of the existing literature demonstrates the complicated dynamics between state politics, healthcare providers, and irregular migrants, all of which are in tension with one another. Much of the literature has framed these dynamics as threatening in their capacity to impact human life, paying close attention to the manner in which political ideology

29 Ibid.
31 Miklavcic, 498–499.
32 Ibid, 503.
34 Ibid, 10.
underpins the healthcare system and governs the clinical setting. There is, however, a general absence in exploring the more contentious notion that healthcare providers themselves are being used as pawns in enforcing state-sanctioned discriminatory public policy. Moreover, while many of these authors investigate the general attitudes of healthcare providers as they interact with irregular migrants, deciding whether or not to treat, they fail to detail the manner in which the provider’s ethical commitments are confused and harmed in the process. My intended research seeks to explore these shortcomings, confronting these issues and tensions directly in attempts to expose the politicization of not only healthcare services, but providers. Given the sheer importance of the medical profession, it is critical to ensure that these providers are able to act equitably and ethically without fear of reproach. By understanding the ways in which providers experience and navigate healthcare policy and ethics when engaging with irregular migrants, we are able to expose the manner in which the Canadian healthcare system creates a discriminatory culture of care at the expense of life.

**Policy & Politics**

Public policy is laws, regulatory measures, courses of action and funding priorities implemented by a governmental body or its representatives which are meant to order and organize a particular society. As such, public policy is not politically neutral, but rather the result of political calculations, deliberations and values of policy makers. Policy is a product of politics. Political entities shape public policy in accordance with their ideological commitments and party values, designing policies which tend to implicitly further their political agenda. The implementation of public policy ensures governmental control while maintaining the guise of national sovereignty. Through public policy, the government has the ability to extend entitlements and rights to its citizens while simultaneously placing restrictions upon their actions.
and behaviours. While only to those recognized as politically legitimate are entitled to national rights, all individuals occupying space within Canadian borders are subject to governmentally dictated constraints. Individuals believed to be in violation of these public policies are considered a threat to the welfare of the nation-state, with their actions understood as an affront to the nation itself.

The design and operation of healthcare systems are governmentally determined and controlled – healthcare policy is public policy. As a result, the rights and entitlements associated with national healthcare access are available only to those of recognized national belonging. As individuals viewed as having breached immigration laws, irregular migrants are necessarily excluded from accessing most social services, and healthcare is no exception. Frontline arguments opposed to broader inclusion of public healthcare often focus on practical concerns such as the costs associated with such provision and the possibility of increased strain on scarce medical resources. In addition, these practical arguments also emphasize immigration policy insofar as the expansion of healthcare access might encourage more illegal immigration, thus threatening national sovereignty. While these practical arguments are typically employed first within the migrant health rights debate, it is ultimately ethical considerations which drive the political decision-making process.

The line of reasoning that “providing care to the uninsured is too costly” functions so to neutralize moral objections. Through the employment of supposedly practical and economic arguments, policymakers and government representatives attempt to distract from the underlying ethical reasons for the exclusion of irregular migrants. Evidence-based and cost-effective solutions do exist, however, such solutions are rarely if ever explored by governing bodies.

35 Gottlieb and Ben Mocha, 354.
36 Ibid.
37 Ibid.
Moreover, studies of U.S. health centres with uninsured immigrant populations have demonstrated that hospital use and healthcare costs decline when primary care is made available to the uninsured.\textsuperscript{38} In reality, restricting irregular migrants’ access to healthcare increases financial and economic costs.\textsuperscript{39}

Immigration policy objectives shape state approaches to healthcare provision for irregular migrants.\textsuperscript{40} Underpinned by ethical judgements such as deservingness, national belonging, and the socio-economic threat of the immigrant “other”, policy arguments in the migrant health rights debate illustrate national insecurity. The prospect of illegal immigration indicates a lack of control which undermines governmental power. As such, by excluding these communities from accessing rights such as healthcare, the government reinforces the importance of authorized national belonging, implicitly punishing defectors. To the government, irregular migrants do not belong and are ineligible for national membership as a result of their immigration status.\textsuperscript{41} Their ineligibility for membership results from their perception as a threat to the internal and external dimensions of national sovereignty, particularly the nation’s power to control its borders and social body.\textsuperscript{42} Because they have circumvented official and authorized avenues of entrance, irregular migrants are classified as undeserving of public goods, and our healthcare policy reflects that.

**Canadian Healthcare Policy, Legislation & Ethics**

In this section I will explore federal as well as provincial healthcare policy and legislation, as well as the ethical principles that govern Canadian healthcare providers. I will also

\textsuperscript{38} Caulford & D’Andrade, 726.
\textsuperscript{39} Gottlieb and Ben Mocha, 358.
\textsuperscript{40} Emphasis added.
\textsuperscript{42} da Lomba, 359.
briefly highlight Canada’s commitment to the United Nations Declaration of Human Rights which outlines Canada’s responsibilities towards all people as a signatory of this statement.

The Canada Health Act (CHA)

The Canada Health Act (CHA) of 1984 is Canada’s federal legislation governing publicly funded healthcare.\(^{43}\) The CHA sets out the criteria, conditions, and objectives of Canadian health services.\(^{44}\) The CHA explains that the primary objective of Canadian healthcare policy is “to protect, promote, and restore the physical and mental wellbeing of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”\(^{45}\) The purpose of the CHA is to ensure that all eligible Canadian residents have reasonable access to insured health services on a prepaid basis.\(^{46}\) The Act lists five conditions which provincial and territorial health insurance plans must respect if they are to receive federal cash contributions: public administration, accessibility, comprehensiveness, universality and portability.\(^{47}\) In order to qualify as an insured person under the Act, one must be a provincial resident.\(^{48}\) A resident is defined as, “a person lawfully entitled to be or to remain in Canada who makes his home and is ordinarily present in the province, but does not include a tourist, a transient or a visitor to the province.”\(^{49}\) Given that they are not ‘lawfully entitled’ to be or remain in Canada, irregular migrants are unable to access care under the CHA. It is imperative to scrutinize this legislation for it is the basis whereby individuals who do not classify as Canadians or residents are excluded and alienated from lifesaving and sustaining care. The CHA operates as the legal framework for

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\(^{44}\) Ibid.
\(^{45}\) Ibid.
\(^{46}\) Ibid.
\(^{47}\) Ibid.
\(^{48}\) Ibid.
\(^{49}\) Ibid.
healthcare providers and accessors, governing their interactions and demonstrating the political underpinnings of Canadian healthcare systems.

The Interim Federal Health Program (IFHP)

In Canada, the Interim Federal Health Program (IFHP) provides limited, temporary coverage to individuals ineligible for provincial or territorial health insurance. Groups that may apply for the IFHP include refugee claimants, protected persons, resettled refugees and “certain other groups.” IFHP coverage includes basic, supplemental, and prescription drug coverage which continues until the beneficiary leaves Canada or becomes eligible for provincial or territorial health insurance. Famously, the 2012 Conservative federal government announced astonishing cuts to the IFHP - cuts which resulted in a distressing number of Canadian newcomers being denied access to basic healthcare. These cuts effectively minimized the claims of non-residents, denying them critical health services on the basis of immigration status. In addition, these significant cuts caused great confusion among healthcare providers who were unsure as to who was “deserving” of care. Fortunately, a legal challenge launched in 2014 saw success as a federal court ruled that the cuts to IFH were consistent with “cruel and unusual” treatment, ordering the full reversal of the cuts. The successful challenge cited the cuts as a violation under the Canadian Charter of Rights and Freedoms. As evidenced, execution of this program has been steeped in political ideology, finding itself subject to the decisions made by those in positions of political power - decisions that harm accessors and confuse providers. As it

51 Ibid.
52 Ibid.
54 Ibid.
stands, IFH coverage is still extremely difficult to obtain, with many irregular migrants finding themselves denied time and time again.

Ontario Health Insurance Plan (OHIP)

In Ontario, healthcare is accessed through the Ontario Health Insurance Plan (OHIP). OHIP covers many health services, protecting those who qualify from the exorbitant costs of medical care. Under OHIP, individuals are able to access emergency services, visit a physician and receive most medical tests and surgeries at no cost. In effect, OHIP allows eligible Canadians and residents to ensure the preservation and maintenance of their health and wellbeing. As such, OHIP governs the interactions between accessors and providers within Ontario. To qualify for OHIP, you must physically be in Ontario for 153 days in any 12-month period, be physically present within Ontario for at least 153 days of the first 183 days immediately after you began living within the province and make Ontario your primary home. In addition to meeting all of the aforementioned requirements, eligible individuals must meet one of the following supplementary requirements:

1. are a Canadian citizen or are a permanent resident
2. are an Indigenous person (registered under the federal Indian Act)
3. have applied for permanent residence, and Immigration, Refugees and Citizenship Canada has confirmed that:
   3.1. you meet the eligibility requirements to apply
   3.2. you have not yet been denied
4. are in Ontario on a valid work permit and are working full-time in Ontario, for an Ontario employer, for at least six months
   4.1. your spouse and any dependents also qualify if you do
5. are in Ontario on a valid work permit under the federal Live-in Caregiver Program
6. are a convention refugee or other protected person (as defined by Immigration and Refugee Board of Canada)
7. have a Temporary Resident Permit (only certain case types, e.g. 86 through 95)

56 Ibid.
57 Ibid. Emphasis Added.
8. are a clergy member who can legally stay in Canada and is ministering full time in Ontario for at least six months

8.1. your spouse and any dependents also qualify if you do

Usually ineligible under all of these criteria, irregular migrants find themselves in absolute isolation. Most categories for permanent residency do not allow for a person who has been living in Canada without status, with notable exceptions made for individuals who can secure sponsorship from a Canadian citizen or permanent resident. For individuals unable to meet these criteria, they may consider submitting an application for permanent residency on humanitarian and compassionate grounds, however, H&C approvals are far and few between. As such, most irregular migrants are excluded from OHIP which sees them turned away from hospitals and clinics if they cannot manage the upfront costs of care. And for those whose conditions are severe enough to warrant an immediate medical response, they find themselves crippled by the unmanageable medical debt that results from the preservation of their life.

United Nations’ Universal Declaration of Human Rights

Moreover, as a signatory to the United Nations’ Universal Declaration of Human Rights, Canada is obliged to guarantee accessible healthcare for all domestic individuals in supporting the ‘right to life’ acquired by virtue of personhood. The relevant components of this declaration are as follows:

1. Article 1

1.1. All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.

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59 Ibid.
60 Caulford and D’Andrade, 727.
2. Article 3
   2.1. Everyone has the right to life, liberty and security of person
3. Article 25
   3.1. Everyone has the right to a standard of living adequate for the health and wellbeing of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

Encouraging basic access to human rights, this declaration ensures the equal and dignified treatment of all persons, as well as the rights of individuals to life and medical care so to preserve health and wellbeing. Recalling the case of Nell Toussaint, Nell filed a complaint to the United Nations Human Rights Committee, arguing that as a result of her exclusion from Canadian public healthcare, her rights to life and equality under international law were contravened.62 Unsurprisingly, the Committee agreed, calling upon Canada to extend essential health services to irregular migrants such that they are entitled to life where life-saving services are available.63

**Canadian Medical Association (CMA) Code of Ethics and Professionalism**

In addition to federal and provincial policy and legislation, the medical profession is governed by the Canadian Medical Association (CMA) Code of Ethics and Professionalism. The CMA sets forth the ethical and professional commitments and responsibilities of the medical profession.64 The purpose of The Code is to provide “standards of ethical practice to guide physicians in fulfilling their obligation to provide the highest standard of care and to foster patient and public trust in physicians and the profession.”65 Importantly, The Code intends to

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62 Kansal and Agarwal.
63 Ibid.
65 Ibid.
inform ethical decision-making in situations where values and principles may be in tension.66

The commitments and virtues outlined in the Code are fundamental to the ethical practice of medicine. Here, I have outlined those values, virtues, and principles presented within The Code that are in tension with legislation and healthcare policy.67

1. **Virtues Exemplified by the Ethical Physician**
   1.1. **Compassion**: A compassionate physician recognizes suffering and vulnerability, seeks to understand the unique circumstances of each patient and to alleviate the patient’s suffering, and accompanies the suffering and vulnerable patient.

2. **Fundamental Commitments of the Medical Profession**
   2.1. **Commitment to the well-being of the patient**
       2.1.1. Consider first the well-being of the patient; always act to benefit the patient and promote the good of the patient. Provide appropriate care and management across the care continuum. Take all reasonable steps to prevent or minimize harm to the patient; disclose to the patient if there is a risk of harm or if harm has occurred. Recognize the balance of potential benefits and harms associated with any medical act; act to bring about a positive balance of benefits over harms.

   2.2. **Commitment to respect for persons**
       2.2.1. Always treat the patient with dignity and respect the equal and intrinsic worth of all persons. Never participate in or support practices that violate basic human rights.

   2.3. **Commitment to justice**
       2.3.1. Promote the well-being of communities and populations by striving to improve health outcomes and access to care, reduce health inequities and disparities in care, and promote social accountability.

3. **Professional Responsibilities: Patient-physician relationship**
   3.1. Accept the patient without discrimination (such as on the basis of age, disability, gender identity or expression, genetic characteristics, language, marital and family status, medical condition, national or ethnic origin, political affiliation, race, religion, sex, sexual orientation, or socioeconomic status). This does not abrogate the right of the physician to refuse to accept a patient for legitimate reasons.

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66 Ibid.
67 Ibid.
4. **Physicians and Society**

4.1. Support the profession’s responsibility to promote equitable access to health care resources and to promote resource stewardship.

4.2. Contribute, individually and in collaboration with others, to improving health care services and delivery to address systemic issues that affect the health of the patient and of populations, with particular attention to disadvantaged, vulnerable, or underserved communities.

As illustrated, the commitments and virtues outlined within The Code seem to afford all people - regardless of affiliation - equitable access to healthcare services and resources. The Code encourages medical professionals to provide all patients the best possible care, extending compassion and respect to all accessors equally. Physicians are required not to discriminate against individuals, respecting the “equal and intrinsic worth of all persons.”\(^{68}\) Of critical importance is The Code’s assertion that physicians “**never** participate in or support practices that violate basic human rights.”\(^{69}\) Here, the fundamental tension between providers and policies is explicit. While healthcare ethics condemn unequal treatment and discrimination, iterating the importance of upholding basic human rights, governmental legislation and policy has designed a system whereby access is inextricably connected to legal status.

**The Canadian Healthcare System - From Theory to Practice**

It is important to recognize that the previously discussed legislation, policies and ethical guidelines are expected to operate in tandem. Immediately apparent is the inherent tension between Canadian federal and provincial legislation and policy, and professional ethics as well as Canada’s responsibility to the United Nations, the latter two which are in general agreement. Ultimately, the Canadian healthcare system is controlled by federal and provincial governments. While the federal government is responsible for drafting and ensuring compliance with the

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\(^{68}\) Ibid.

\(^{69}\) Ibid. Emphasis added.
Canada Health Act and issuing coverage under the Interim Federal Health Program, the provincial governments are responsible for the execution and organization of their own healthcare systems. By virtue of their existence, these governments are inherently political, allowing their ideology to drive the design and implementation of these vital services. Only once healthcare systems may be understood as a materialization of state interests are we able to recognize the way by which the government controls therapeutic power.  

In restricting healthcare access to ‘authorised’ citizens and residents, the Canadian healthcare system entangles the right to life with political legitimacy. Through advertisement of Canadian healthcare as ‘universal’ the government garners national praise, as the social body assumes this to include all individuals living within Canadian borders. With this, the social body is unable to bear witness to the discriminatory stipulations that allow this system to be complicit in the ill health and even death of members of our most vulnerable communities. Through the enactment of exclusionary policy and legislation, nation politics adversely impact life and professional practice. Healthcare agents possess highly specialized and exceptional skills, thereby making them members of a class composed of the ‘few’ capable of supporting the lives of the ‘many’. Through the restrictions placed upon these highly valuable individuals, the government exercises control over the health and wellbeing of the population, categorizing individuals as worthy and unworthy in accordance with their political agenda.

The language encased in these federal and provincial pieces of legislation are clear in their assertion that only those approved by the government are to be serviced, demonstrating the control complex that leaves our government feeling scornful towards those that undermine their authority. As a ‘free and democratic country’, Canada is unlikely to make this disdain explicit.

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70 Kivelä and Moisio, 41.
choosing instead to implicitly punish these ‘rule-breakers’ by limiting if not completely removing their access to life-supporting care and resources. Of most concern, however, is the manner in which the government exercises this control, casting providers as de facto immigration enforces tasked with upholding these exclusionary mandates.\footnote{DeShalit, Edmonds and Sidhu, 69.} If I may be allowed a temporary digression, I wish to assert that in no way, shape, or form am I condemning or criticizing healthcare providers - it is my strong belief that these individuals are so incredibly selfless, skilled and worthy of endless praise. I am, however, condemning and criticizing the healthcare system for manipulating them in such an unethical and harmful way. As the actors physically carrying out these policies, the state is effectively using them as tools to further its political agenda and punish its renegades. Through the manipulation of providers, the state acts as the gatekeeper to life.

**Ethical Dilemmas in the Delivery of Care**

Providers are tasked with “downloading” these policies and legislative provisions, allowing them to guide their practice. In addition to these legal guidelines, providers are also accountable to their professional ethics which encourage non-discriminatory practice and equitable access to health services and resources. Responsible for internalizing and concretizing both, providers fall victim to role confusion where their decisions to treat call upon them to strike a seemingly impossible balance between their ethics and the law. Front-line healthcare workers are being tasked with stratifying human suffering while simultaneously being asked to identify all people as deserving of equal treatment.

The decision to report on a patient’s immigration status requires the provider to strike a balance between patient confidentiality and medical needs, and the public interest.\footnote{Hooi-Ling Harrison and Gavin Daker-White, “Beliefs and challenges held by medical staff about providing emergency care to migrants: an international systematic view and translation of findings to the UK context,” *BMJ Open* 9, no. 7 (2019): 10.} The
prospect of reporting complicates the role of the provider while adversely affecting the mental and physical health of the patient who might choose not to seek care for fear of deportation.\textsuperscript{73} Studies have demonstrated that when confronted with an uninsured patient accessor, physicians tend to operate under a “don’t ask, don’t tell” policy so to protect both themselves and their patients.\textsuperscript{74} Here, patient needs for medical care are prioritized over governmental desires to apprehend illegal migrants. The idea that providers of life-saving services would have to play a part in the deportation of a medically compromised and vulnerable individual demonstrates the power of politics and wide-reaching arm of the state. Healthcare providers are not political enforcers; in fact, their ethical obligations require their impartiality. The role of the provider is to deliver the best possible care in a non-discriminatory manner, yet through the employment of exclusionary policy and legislation, the state attempts to regulate the delivery of care in such a way that is necessarily inconsistent with the ethical function of the provider.

Moreover, healthcare providers inclined to care for irregular migrants encounter further difficulties in the delivery of care because of the financial limitations of their patients.\textsuperscript{75} The financial burden of healthcare for the medically uninsured further impedes access, as patients lack the financial resources necessary to acquire care. This financial hurdle additionally implicates the practitioner who must determine whether to provide care and how it may be provided in light of fiscal limitations. The ethical requirement for providers to act with compassion is in friction with their expectation to staunchly bill patients they know are unable to bear the financial burden. To make matters worse, such a financial burden has the capacity to generate great psychological distress, which may further jeopardize the mental, physical and emotional health of the patient. This threatens to undermine their commitment to the wellbeing

\textsuperscript{73} Miklavcic, 502.
\textsuperscript{74} Miklavcic, 505; Suphanchaimat et al., 12; Harrison and Daker-White, 9.
\textsuperscript{75} Miklavcic, 503.
of the patient which requires them to bring about a positive balance of benefits to harms.

Oftentimes, providers look towards ‘loopholes’ which enable them to exercise discretion in decisions to treat regardless of prepayment or monetary acquisition. Studies on this particular dilemma have found that physicians commonly look towards NGO’s for assistance, even going so far as ordering laboratory samples in their own name. Unfortunately, these decisions are to some extent, in tension with the law, placing them at risk. These findings, however, demonstrate that many practitioners are willing to assume this risk in favour of delivering medically necessary services, illustrating the importance of ethical commitments in light of restrictive healthcare policy.

An additional ethical dilemma lies within the tension between the framework of healthcare as a human right, which is in general alignment with professional ethics, and the framework of state-driven policy and regulation. Independent of policy and legislation, the duties of healthcare providers emerged from professional norms and ethics, the primary function of which is to ensure the health of all human begins, regardless of nationality or ethnicity. Many Canadian health providers report that they are cognizant of their professional and ethical duty to deliver universal health care yet feel great tension between this humanitarian obligation and their accountability to law and policy. By virtue of these inherently contradictory frameworks, providers are almost forced to select one at the expense of the other. These difficult decisions have the potential to generate distress among providers, as they weigh the relative risks and benefits of each option, attempting to strike a seemingly impossible balance between the welfare of themselves, the state, and the patient. It has been argued that healthcare providers find it

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76 Suphanchaimat et al., 10.
77 Ibid.
79 Suphanchaimat et al., 8.
80 Miklavec, 511.
emotionally challenging to service irregular migrants as the legal and ethical dilemmas associated with caring for this population contribute to feelings of distress. Utilizing their own judgement in making legal and moral calculations puts providers under substantial pressure, leading to emotional affliction and frustration. Some providers have gone so far as to remark that such experiences generate feelings of demoralization. In understanding these nuanced yet impactful ethical dilemmas and conflicts, we are able to witness the harms that these incongruous politically driven decrees perpetrate onto providers and their non-status patients.

Discussion

A Note on Public Health

An interesting exception to the Canadian case is the extension of care to irregular migrants in the case of communicable disease. The reasoning behind this scant exception is that providing free preventative and curative treatments in the case of these diseases acts as a safeguard of public health. It seems then, that irregular migrants are only afforded healthcare rights insofar as they pose a risk to the well-being of society at large. For example, in the case of pandemic or endemic diseases, such exclusionary policies would jeopardise public health protection. To further contextualize this special case, one may look at current global pandemic COVID-19 and Canada’s response as it concerns safeguarding public health. Ontario, for example, has announced that in order to ensure that the province continues to protect to health and well-being of Ontarians, all individuals in need of relevant COVID-19 related care may access such services. As such, Ontario is waving the three-month waiting period for OHIP coverage and will be covering the cost of COVID-19 related services for uninsured individuals.

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81 Kavukcu and Altintas, 194.
82 Ibid.
83 Ibid.
84 da Lomba, 369.
who do not meet the criteria for OHIP coverage. The purpose of such exceptions is two-fold: these measures aim to combat the discouragement that many uninsured migrants feel when accessing health services without the requisite finances, and these amendments attempt to protect the health of the greater public. These special cases raise the question of why basic healthcare is not already accessible to irregular migrants, as simply offering basic health maintenance to all individuals would mitigate public health risks. Importantly, transitioning these ‘exceptional measures’ into basic healthcare rights would result in the preservation of human life and reduce those ethical dilemmas which adversely and unjustly impact healthcare providers.

**Avenues for Further Research**

While this particular study does investigate the tensions between Canadian healthcare policy, healthcare providers and irregular migrants, there is still much to be explored within these complex relationships. I would recommend that studies investigate how these relationships impact the self-concept of the provider insofar as they compromise the providers understanding of themselves as a professional and as an individual. Moreover, while some research has touched upon the potential benefits of extending basic healthcare to all individuals living with a country’s borders, there is certainly room for a more comprehensive review of such benefits. The aforementioned research would serve to demonstrate the feasibility of a truly universal healthcare system with the potential to encourage advocacy and meaningful macro-level change. Finally, I recommend that more research be dedicated to exploring the unique and significant experiences of irregular migrants who engage directly with the healthcare system. Critically analyzing the interactions between irregular migrants and front-line providers works to not only give voice to these marginalized and often discounted voices, but also to bear witness to the manner in which governmentally imposed policy impacts the delivery of care in the everyday.
Conclusion

It seems intuitively wrong to understand the clinic as inaccessible to the sick, just as it seems immoral to conceptualize the healthcare provider as an arm of the state. People look towards the healthcare system in their most vulnerable and trying times, putting their complete confidence in healthcare professionals. Determining who is and is not worthy of these life-saving services on the basis of citizenship and political legitimacy represents survival as a political project. Unfortunately, within the Canadian clinic, the ‘right to life’ translates to ‘the [authorized] right to life’, as citizenship and legal status operate as the fundamental prerequisite in obtaining care. The discriminatory policies which underlie the Canadian healthcare system, justifying and encouraging the exclusion of irregular migrants, manipulate the healthcare provider so to create role confusion while harming the very individuals that these professionals are meant to protect.

The Canadian healthcare system effectively controls therapeutic power by reinventing the healthcare provider as an enforcer of discriminatory politically charged policies by holding them accountable to inherently prejudicial policies. This manipulation threatens the ethical commitments of the provider who understands themself as responsible for the preservation and maintenance of human life. While studies conducted by Miklavec and Suphancharimat et al. found that Canadian providers often ignored the legal status of accessors, acting with compassion and in accordance with their moral frameworks by prioritizing the needs of the patient, I assert that providers should not have to make these potentially compromising decisions in the first place.

Exercising biopower over the population - and utilizing healthcare providers to do so -

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85 Caulford and D’Andrade, 726.
Canada has the capacity to choose when to foster life, and when to allow that life to end. In recognizing this power and practice, we as a society are able to bear witness to the suffering of the socially marginal who live their lives in fear, wanting nothing more than a place to call home. By paying attention to the problems confronted by these equally valuable lives, we may lobby for change, improving the lives for all who live peacefully within our borders. In effect, the Canadian healthcare system creates and encourages a culture of care whereby the lives of some are intrinsically more valuable than others by virtue of national validation.\footnote{Miklavcic, 497.} In our ‘free and democratic’ nation, this sends the message that the social and physical body is at the mercy of the government, existing only so far as the nation allows it to – a distressing reality if nothing else.
WHERE YOU CAN YOU GO IF YOU NEED CARE.

Please note that these are Ontario specific resources for the medically uninsured.

**Canadian Centre for Refugee and Immigrant HealthCare**
4158 Sheppard Ave East
Scarborough, ON
#: 1-647-267-2176
https://www.healthequity.ca/
Paediatric Clinic, Dental Clinic, Chiropractic Clinic, SWAN
Women’s Clinic, Community Volunteer Clinic

**Davenport Perth Clinic**
1900 Davenport Road
Toronto, Ontario
#: 416-658-4812
http://dpnchc.com/health/
Medical Services, Physiotherapy Services, Counselling Services, Community Health Clinic
*Neighbourhood specific*

**The West End Non-Insured Walk-In Clinic**
761 Jane St, 2nd Floor
Toronto, ON
#: 416-760-2810
https://accessalliance.ca/c4cc/
*DROP IN ONLY*
Midwife available on Thursdays, Medical Clinic

**FCJ Refugee Centre**
208 Oakwood Avenue
Toronto, ON
#: 416-469-9754 ext. 230
http://www.fcjruefugeecentre.org/our-programs/settlement-programs/health-clinic/
Primary Care Clinic, Mental Health Services

**The Bay Centre for Birth Control**
76 Grenville St. Floor 3
Toronto, ON
#: 416-351-3700
https://www.womenscollegehospital.ca/care-programs/bcbb/
Sexual Health Centre, Abortion Care, Reproductive Health Care, Contraceptive Health Care

**Women’s Health in Women’s Hands**
2 Carlton Street, Suite 500
Toronto, ON
#: 416-595-7655 ext. 7
https://www.whiwh.com/
*Available for racialized women*
Sexual & Reproductive Health Care, Prenatal & Postnatal Care, Mental Health Care

**Family & Walk-In Medical Clinic**
780 Burnhamthorpe Rd. West, Unit #4
Mississauga, ON
#: 905-506-857
https://welcomemedicalclinic.wordpress.com/
Medical Clinic, Women’s Health Care, Mental Health Care

**IMPORTANT INFORMATION FOR UNINSURED INDIVIDUALS IN NEED OF HEALTH CARE**
- Call and confirm your eligibility with the clinic prior to arrival
- Appointments may be required
- If available, please bring a list of your current medications & medical records
- Note that these clinics provide episodic care. Please contact your local Community Health Centre (CHC) for information about getting a primary care provider (i.e. family doctor)

**NOTE:** These clinics do not provide emergency care. If you are having a medical emergency call 911

Please Note that this is not an exhaustive list.
Please feel free to redistribute these materials to relevant service providers or the medically uninsured.

IMPORTANT INFORMATION FOR UNINSURED INDIVIDUALS IN NEED OF HEALTH CARE

- Most of these clinics offer services free of charge to the uninsured, and operate under “access without fear” principles. With that, some of the services offered at these clinics do come at a small fee. Contact the clinic for further details.
- Note that in the case of pandemic diseases (i.e. COVID-19) exceptions are made that typically extend relevant healthcare to the uninsured.
- Go to https://www.allianceoncon.ca/ to find a Community Health Centre near you.

Parkdale Queen West Community Health Centre
https://pqwchc.org/contact/service-area-catchment/

PARKDALE SITE
1229 Queen Street West
Toronto, ON
 #: 416-557-2455

QUEEN WEST SITE
168 Bathurst Street
Toronto, ON
 #: 416-703-8480
*Neighbourhood specific sites

Medical Care, Physiotherapy, Dental Services, Psychiatry Services, Dietician Services, Chiroprody (Foot Care), Naturopathic Care Services

Muslim Welfare Centre
100 McLevin Avenue, Unit 2A
Scarborough, ON
 #: 647-641-1027
https://www.muslimwelfarecentre.com/causes/free-clinic/
*Note that this clinic is available to all uninsured persons, irrespective of religion

Medical Clinic, Women’s Health Care, Mental Health Care

East End Community Health Centre
1619 Queen Street East
Toronto, ON
 #: 416-778-5858
https://eastendchc.on.ca/
*Neighbourhood specific*

Medical Clinic, Psychotherapy, Services, Physiotherapy, Nutrition Support, Footcare

Regent Park Community Health Centre
465 Dundas Street East
Toronto, ON
 #: 416-364-2261
http://www.regentparkchc.org/health-services/primary-health-care
*Neighbourhood specific*
Medical Clinic, Mental Health Care, Footcare, HIV/AIDS Care, Pre & Post Natal Care

Association of Ontario Midwives
365 Bloor Street East, Suite 800
Toronto, ON
 #: 416-425-9974
https://www.ontariomidwives.ca/client-populations
*You do not have to have OHIP coverage to access an Ontario Midwife

The Four Villages Community Health Centre
https://4villageschc.ca/

BLOOR SITE
1700 Bloor Street West
Toronto, ON
 #: 416-604-5551

DUNDAS SITE
3446 Dundas Street West
Toronto, ON
 #: 416-604-5552
*Neighbourhood specific sites

Medical Care, Physiotherapy, Dietician Services, Footcare
Bibliography

https://www.ontario.ca/page/apply-ohip-and-get-health-card


