

'Suspect' screening: the limits of Britain's medicalised borders, 1962–1981

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Like their peers across western Europe, Australia and the Americas, large segments of the British public and a significant proportion of Britain's medical establishment have enthusiastically promoted medical screening (and de facto medical selection) of would-be migrants since World War II. Politically, such medicalised controls have been relatively uncontroversial both domestically and internationally, and across Europe have arguably provided 'objective' scientific cover for efforts in fact directed towards controlling the entry of migrants from specific ethnic groups and countries of origin. Targeted groups were, above all, those who were 'racialised': that is, those to whom the receiving nation ascribed homogenising racial identities predicated (implicitly or explicitly) on phenotypical or biological as well as cultural and behavioural differences.¹ However, despite widespread enthusiasm for medical selection of migrants in Britain, the implementation of genuinely restrictive or exclusionary health controls on migration proved challenging.

Immigration policy in Britain was shaped by a number of distinctive geopolitical and cultural constraints after World War II. At least initially, these delivered migration policies favouring relative generosity towards postcolonial migrants, not least to avoid the appearance of racism. Large-scale migration to Britain in this period began in the context of post-war reconstruction. The consequent labour shortages militated strongly against restrictive border controls. Simultaneously, despite the lingering after-effects of a devastating war, Britain envisioned itself as a 'tolerant nation with liberal traditions', mother to a multiracial empire and Commonwealth.² For a considerable period, the interplay between these factors, operating in the wider context of the Cold War, played a powerful ideological role

in the UK. Significant changes in medical knowledge, ethics and practices across this period also shaped the art of the (medically) possible at the border. Finally, and uniquely, from 5 July 1948, the UK operated a comprehensive national health service, funded almost entirely from general taxation, and (at least initially) free at the point of need. Crucially, legal migrants to the UK, like all other residents, were entitled to use the health services immediately upon arrival, irrespective of whether they had yet contributed to the system through income, business or property taxes.

To explore the implications of these interwoven factors for the British use of medical tools in the management of migration, this chapter will focus on the emergence, extension and effects of medicalised immigration control for migrants originating from the UK's 'New Commonwealth'. Common across migrant-receiving nations since the nineteenth century, medicalised controls hinge on the application of medical expert claims, knowledge and technologies to evaluate migrant bodies and groups for both inclusionary and exclusionary purposes. Britain's new regime developed between 1962, when the first Commonwealth Immigrants Act [CIA62] stripped British subjects from the colonies and Commonwealth of their automatic right of abode in the UK, and 1981, when a new British Nationality Act [BNA81] finally defined an exclusive British citizenship rooted in *jus sanguis* (and available to others only in accordance with an exacting suite of new conditions) and invested such citizens alone with an automatic right of abode.³ Although rhetorically race-neutral, in practice this legislation and the medicalised controls instituted under its remit affirmed the racialisation of migrants coming to Britain from its former colonies, defining them by their physical differences in skin colour and 'exotic' practices of embodiment, rather than by their shared status and experiences as imperial British subjects.

Across this period, the imposition of new medical surveillance and controls generated three separate medicalised zones to be traversed by would-be migrants to the UK. They were spatially and culturally distinct from the largely coincident border spaces and processes that enforced the array of non-biomedical regulations and processes through which migrants were controlled and restricted. Here, I will refer to these medicalised sites of migration control – distinct physical spaces at which migrants were subject to a scopic medical regime – as Britain's 'medical borders'.

Migrants to the UK first encountered an external medical border: exported medicalised inspections in their countries of origin, initially for work-voucher holders and later for their dependants. The second followed Britain's geographical border, where migrants' right to entry was again rendered contingent upon 'health checks' and medical scrutiny. The third, and perhaps most idiosyncratic was internal, located at migrants' 'port of arrival' – their eventual destination in the UK. Here, migrants were obliged to meet any medical conditions set at the port of entry, but also urged and in some cases pressured to comply with the ever-changing requirements of 'hygienic citizenship' in their dwellings and practices of embodiment. In particular, they were exhorted to place themselves under medical surveillance through registration with a family doctor, while other forms of medical surveillance were imposed through environmental health regulations enforced by Medical Officers of Health.⁴ Sold as a 'health measure' intended to protect host communities and migrants alike, this internal border relied heavily on Britain's National Health Service (NHS).

Who were these migrants? They included professional, skilled and unskilled workers and their dependants, principally from Britain's former African, Caribbean and South Asian colonies. Students and visitors (defined as individuals staying for less than six months) from the Commonwealth increasingly fell into the surveillance remit of UK immigration law, but rarely experienced restrictive medical controls in this period and will not be considered here. Migrants from Ireland were exempt from control, but until Britain joined the European Economic Community in 1973, all other nationals were categorised and legally regulated as 'aliens'.

Like most voluntary migrants, New Commonwealth migrants to the UK were generally young and healthy. Most primary migrants were unaccompanied men; the Caribbean also sent substantial numbers of unaccompanied women, with smaller numbers arriving from other destinations. Secondary migrants ranged in age from the very young to the very old: spouses, affianced partners, dependent children and elderly parents all had varying degrees of entitlement to join settled adults in the UK. Nonetheless, repeated epidemiological surveys and other forms of medical surveillance from the 1950s–1970s identified only two significant health 'burdens' presented by New Commonwealth migrants; they experienced higher

rates of tuberculosis and venereal disease than local UK populations.⁵ Popular myth and moral panics also implicated the migrants as vectors of leprosy and intestinal parasites, and as victims of mental disorder, but these claims were not supported by convincing evidence, and were regularly dismissed by ministry officials and medical specialists.⁶

Before turning to the specific details of the UK's medical borders, this chapter will examine the legislation that gradually enabled medical control. Having established the legal powers which underpinned medical controls on the movements of British subjects, I will turn to questions of practice: what do we know about what actually happened at Britain's medical borders at home and abroad? Finally, it will explore the reasons why Britain's two domestic medical borders remained highly porous in the face of wider trends towards the implementation of strict medical regimes of immigration control and exclusion.

The legal foundations of medical control in Britain

Associations between immigrants and infection are deeply rooted and persistent in British culture, becoming florid in the nineteenth century, when epidemics of cholera and typhus were linked to Irish newcomers.⁷ However, unlike many of its settler colonies and the United States of America, the United Kingdom neither legally restricted the migration of specific racialised groups nor implemented ongoing migrant medical inspection between the 1870s and 1900. Even long-established regimes of port sanitary inspection and quarantine for ships arriving from known infected ports faced opposition for their incompatibility with both the economics of empire and 'British liberal principles'. Worse, they were condemned as ineffective.⁸ Only with the 1905 Aliens Act was the free movement of groups of people travelling from non-infected ports restricted by law and made subject to medical clearance. In this instance, the targets of the legislation were east European Jews fleeing pogroms; they were perceived and presented by anti-immigrationists as threatening the nation on both economic and racial grounds, rhetorical claims that would reappear prominently in the post-war era. Medical justifications for exclusionary controls, however, seemed to offer 'more honourable' grounds for exclusion than either lucre or prejudice.⁹

The 1905 Aliens Act finally gave British officialdom the power to regulate and restrict the entry of 'alien' immigrants (but not migrating

British subjects) at Britain's ports. It enabled immigration officers to exclude or expel 'undesirable' aliens for crime, dependency, disease, or once landed, 'living under insanitary conditions'.¹⁰ The Act notably also placed the burden of proving that they were not aliens on the immigrants themselves.¹¹ It did not define 'alien', though it did explicitly exempt those born in the UK of British subject fathers from exclusion on economic grounds.¹² The 1905 Act was followed by a succession of wartime and interwar acts and orders intended to control 'enemy aliens', including the notorious 1920 Order which included an array of medical controls on 'alien' entrants to the UK.¹³ However, British subjects from across the multiracial empire remained exempt from any form of legal restriction on migration until after World War II.

As Hansen and others have argued, the persistence into the post-war period of Britain's 'Open Door' for Commonwealth migrants reflected British political, financial and affective investments that were unevenly distributed across her subject populations.¹⁴ Australians, New Zealanders, Canadians and the white settler populations of East and South Africa were, like the Irish, regarded as 'kith and kin' with whom economic and cultural ties were to be maintained at all costs. In contrast, the 'coloured' populations of Britain's tropical colonies and New Commonwealth figured in popular discourse as 'aliens' despite their shared status as British subjects.

Throughout the post-war and Cold War periods, officials at the Home and Colonial Offices were at pains to correct this confusion publicly, whatever their private views. Moreover, the 1948 British Nationality Act [BNA48] appeared to reinforce and codify inclusive notions of a shared and stable imperial citizenship. Yet beneath the surface, Whitehall's civil servants and their political masters in Westminster responded to increasing rates of migration from the New Commonwealth to Britain with a mixture of anxiety and hostility. These inchoate tensions surfaced regularly in parliamentary debate. Some, like Henry Hopkinson, Minister of State for the Colonial Affairs, were determined to maintain Britain's standing as the racially tolerant and liberal 'mother' to a multiracial Commonwealth.¹⁵ Others in Parliament believed that only racially targeted immigration restriction would prevent violent popular racism from taking hold in Britain itself.¹⁶

Successive post-war governments charged their civil servants with uncovering the impacts of racialised migration, either to justify

Britain's 'Open Door', or to generate a race-neutral rationale for closing it. They completed a series of investigations between the 1948 arrival of the *Empire Windrush* and her 802 Caribbean passengers, and the 1961 introduction of the Commonwealth Immigrants Bill.¹⁷ But these studies uncovered little evidence of any significant problems which could be laid at the migrants' doors. Housing was certainly in short supply but as newcomers, few migrants met local criteria for receiving public housing, public outcry notwithstanding. In the full-employment labour market, migrants were rarely unemployed for long, and they committed fewer crimes proportionately than their British-born peers. Nor did they significantly burden the new National Health Service. Medical experts even suggested that their higher rates of tuberculosis and venereal disease were due to exposure in the UK.¹⁸ At the same time, the newcomers provided, from the outset, a significant proportion of the NHS workforce, as they did for other key public services. Beyond the politically unpalatable suggestion that their mere visibility triggered racism, civil servants found no specific grounds to exclude the new racialised migrant groups.

In 1961, restrictive legislation was nevertheless introduced for Parliamentary debate. Controversial and highly contested, the Bill that would become CIA62 passed through Parliament in the shadow of an outbreak of smallpox inadvertently carried to the UK by migrants from Pakistan desperate to 'beat the ban' they expected to follow. In part, as a result of this coincidence, the Act for the first time introduced the specific power to medically inspect and if necessary exclude British subjects not of UK origin at the border. Moreover, medical inspectors were explicitly entitled to demand 'any test or examination required' in order to satisfy themselves of health of an intended migrant.¹⁹ This power was intended specifically to enable radiographic screening for tuberculosis at Britain's borders.

The 1962 Act was repeatedly renewed in the 1960s, and then supplanted by more restrictive laws. In 1965, the milestone White Paper on Commonwealth Immigration advocated extending Britain's medicalised border outwards to migrants' countries of origin, where its costs could be imposed on the migrants themselves. As we will see, while it was long-established practice in the United States and in some European nations, implementing offshore medical inspections proved challenging for Britain.²⁰ In part, Britain was hampered by

the complicated geopolitical position I have mentioned above; in part, by the continuing legal complexities generated by the migrants' status as British subjects. Medical underdevelopment in migrants' nations of origin – underdevelopment which many attributed to British imperial neglect – also played a role in undermining medical selection and screening. So too did the existence of the NHS; experts, politicians and members of the public alike understood that the service depended heavily on migrant labour and, through its voracious demand for professional staff, actively contributed to a damaging clinical brain drain from the global South to the global North. Nonetheless, by 1968, most primary migrants were medically screened abroad.

The 1968 Commonwealth Immigrants Act [CIA68] extended medical controls from Britain's ports and airports into the British interior, mandating that any Commonwealth migrant whose entry was subject to control could also be required as a condition of admission to report to local health authorities for further surveillance and screening after entering the UK, in the 'interests of public health'.²¹ The wives and young children of settled Commonwealth migrants remained exempt from exclusion or inspection under this Act, but could be landed subject to such medical conditions. And in 1969, the Immigration Appeals Act smuggled in a new requirement that the dependants of primary migrants gain Entry Certificates before coming to the UK. For all but the closest family members, this entailed medical examination. As this chapter will discuss below, in practice, entry certification served as a vehicle for medicalising the certification of 'entitlement' even for these protected groups.

Only two years later, the 1971 Immigrants Act codified the existing administrative imposition of mandatory radiographic examination in country of origin for all primary migrants, their dependants over the age of 18, and dependent elderly parents; and mandated port medical inspection of primary migrants' dependants, though not their exclusion on health grounds. British law still could not reasonably require medical examinations before departure for immigrating spouses and underage children, since they were entitled to entry irrespective of their health status, but both groups were encouraged to invest in such examinations even though any certificates of health they received abroad bore no legal weight at

Britain's borders, and would not necessarily exempt them from further medical inspection.

Acts in 1981, 1988, 1996, 1999, 2002 and 2004 further restricted immigration and – importantly – responded to the new legal right to freedom of movement enjoyed from 1973–2020 by Europeans as part of the UK's membership in the European Community and, later, European Union. In addition, all primary legislation around entry to the UK was repeatedly reshaped and tightened administratively through changes to the 'Instructions for Immigration Officers' and official guidance to entry clearance officers in Britain's diplomatic outposts abroad. Pressure to re-task medical interventions at Britain's external and geographical borders – officially instituted as health protections for the British public – to serve the wider agenda of drastically reducing inward flows of migration remained intense across this period. Only in 2005, however, did additional pre-departure medical restrictions enter into UK law rather than regulatory guidance.

**Controlling subjects, creating medical borders:
health checks and commonwealth
migrants 1962–1967**

The medical powers to control inward migration of British subjects enacted by CIA62, though not uncontested, were among the least controversial in the measure. I have argued elsewhere that legislators may have found it difficult to protest against these powers at a moment when the UK was experiencing a deadly imported outbreak of smallpox.²² Certainly bureaucrats and medical civil servants within the Ministry of Health, though themselves ambivalent about the need for and efficacy of border medical inspections for non-epidemic disease, were unable to resist their inclusion. CIA62 incontrovertibly granted border agents the power to screen British subjects not only for epidemic conditions already covered by the International Sanitary Regulations, but also for endemic illnesses such as tuberculosis and sexually transmissible diseases. Moreover, from 1962, British law explicitly empowered the exclusion on health grounds of work-voucher holders, both in their countries of origin and at Britain's ports and airports.

Before, during and after the debates that framed the passage of the 1962 Act, popular opinion and professional arguments in favour of such exclusionary screening repeatedly mobilised claims about Britain's welfare state, and especially the National Health Service. As the Ministry's civil servants observed, 'uninformed public prejudice' against the migrants often cited the supposed 'demands they placed on the Health Services'.²³ Nonetheless, in practice, Britain's geographical border remained comparatively free from medicalised controls during this period.

Instead, Britain idiosyncratically internalised its medical border and surveillance of migrants under what became known as the 'port of arrival' system.²⁴ Structurally and functionally, the 'port of arrival' system was a medical border envisioned strictly as a health control, rather than a barrier to transnational movement. Operated by local public health authorities and encompassing environmental health surveillance as well as clinical screening, it relied explicitly on the existence and accessibility of the NHS. Only this system of universal health care, delivered free at the point of need, and the dense network of general and specialist medical providers it entailed, made the deferral of border medical inspections both economically efficient and, at least potentially, epidemiologically effective. And because all landed migrants were instantly eligible for NHS services, radiographic examination costs were massively reduced by using existing systems and equipment, while the Ministry of Health and its successors could argue that receiving communities would be protected from imported illness as long as immigrants were swiftly 'integrated' into the NHS safety net.

But what actually happened at these borders immediately after controls were instituted? Border zones are notoriously sites of multiple and contested agency. Individual migrants and officials; governments in both sending and receiving nations; advocacy groups (whether for or against migration); transnational ethnic communities; state, media and corporate interests; competing expert constituencies; non-human physical entities such as diseases; and the technologies of movement, communication and control, all operate as agents in border spaces. The freedom with which actors in each of the categories can express their agency in and through 'border performances' is constrained by factors including shifting and historically contingent hierarchies of power, relative visibility, and technical intransigence.²⁵

Suspicious practices: enacting control at the geographical medical border

In seeking to understand border health controls, legal mandates and policy advice are of limited value, particularly since most national systems vest individual immigration officers with substantial freedom in exercising their powers. Neither official guidance nor political exigency can successfully constrain the actions of the personnel on the spot, often deeply suspicious of particular migrant groups on both racial and epidemiological grounds.²⁶ Furthermore, even UK government ministries consistently struggled to ascertain reliable information about practices at the nation's ports and airports, to say nothing of the UK's internal medical border where both primary and secondary migrants were intended to experience close medical surveillance and supervision.²⁷

Moreover, while historians and others have mapped the visibility and persistence of medical discourses asserting 'the foreignness of germs' and the need for their expert medical control, in the post-war British context, medical expertise did not translate directly or readily into power.²⁸ Port and Airport Medical Officers had only advisory powers, while the Ministry of Health and its successors were politically weak departments. Britain's Ministry of Health had neither sought nor much desired the power specifically to deploy radiographic screening at the border, yet once enabled by CIA62, came under increasing public pressure to do so. Their preparations reflect this ambivalence. Universal medical screening of all migrants at the border was impossible, given cramped port spaces, scanty facilities, inadequate funding, staff shortages across the health services, and rising numbers of migrants. Much time was therefore spent seeking sensible epidemiological grounds for screening selection while ensuring that the targeted groups would include at least some non-racialised groups.²⁹ While the Ministry feared accusations of 'disingenuousness' if it did not reinforce the medical border, the legislation was fundamentally impractical.³⁰ Ministry staff were hampered, too, by resistance from other, stronger departments across Whitehall, which had no desire to see medical controls infringe on their own powers; deplete their budgets; contribute to their workloads; or add to existing tensions surrounding the decision to restrict the free movement of British subjects.³¹

After CIA62, the Ministry of Health and its border agents were enduringly caught between the public and (non-expert) medical appetite for exclusionary medical inspections and the pragmatic and political forces weighted against such inspection. Public and professional opinion routinely accused the Health Minister of 'neglecting his duty' to prevent importations of disease by immigrants.³² Yet instituting universal high-tech screening at all UK ports and airports, as George Godber, Britain's formidable Chief Medical Officer from 1960 to 1973, noted would be 'extravagant in the use of plant and staff' when Britain's medical fabric desperately required renewal and modernisation.³³ Expending valuable resources to stop the occasional importation of an already endemic and treatable disease was both economic and epidemiological madness.³⁴ But such arguments carried little weight with the public or the medical profession, determined to protect both the gains they had made against endemic tuberculosis and the always impecunious NHS.

In fact, Britain's normal regime of tuberculosis screening and control was so successfully reducing domestic rates of infection that TB wards and sanatoria were closing or being returned to hospitals for other uses. Consequently, the Ministry much preferred approaches that would use border controls only to supplement what were clearly effective standard public health measures.³⁵ Ironically, while popular opinion frothed against a hypothetical immigrant 'burden' on the NHS, it was the Health Service's success that most powerfully rationalised inaction at the geographical border. With the advent of chemotherapies, it was increasingly cheap to treat TB via the NHS but prohibitively expensive to exclude it.

Implementation costs were not the only deterrent to the institution of a thoroughly medicalised, radiographic port regime. The Home Office raised 'grave difficulties of both principle and practice'.³⁶ It rejected any proposals to improve the accuracy of screening if they would retard Immigration Officers' decision-making or involve passengers leaving the port. As they presciently admitted, any such delays invited 'legal challenge' by 'aggrieved' individuals.³⁷ As the volume of informally referred immigrants rose, local NHS hospitals also 'jibbed'. Such referrals incurred costs and interrupted the provision of regular services.³⁸ Blocked from accessing appropriate diagnostic aids, port medical officers were frustrated, and this also worried the Ministry of Health: 'denied access to X-ray facilities ... they

may start to refuse entry to suspects who may subsequently be shown in their own countries not to have T.B.' This would, the Ministry hinted, result in 'awkward' conversations for the Home and Commonwealth offices.³⁹

However, even when it was available, more and better equipment did not necessarily offer a solution. By 1964, when an 'experimental' X-ray scheme at London (later Heathrow) Airport was fully operational, it was clear even to non-medical observers that the system was straining at the seams under ever-increasing volumes of passengers from epidemiologically 'suspect' regions.⁴⁰ Operating under extreme pressure, even with the latest technology, port medical inspections could never provide the impenetrable shield against imported disease envisioned either by the public or by the British Medical Association.⁴¹

**Expecting, experiencing and contesting control:
Britain's domestic medical borders,
1965–1968**

Daily practices at Britain's medical borders in the 1960s and early 1970s are largely opaque; however, clues can be found in a series of contentious individual cases as they criss-crossed Whitehall, circulating between the Home Office and Ministry of Health. Clustered between the influential 1965 White Paper on 'Immigration from the Commonwealth' and CIA68, these cases reveal the complex nexus of competing forces which shaped day-to-day practices of medical inspection before and at the UK border. Here I will explore two in detail; together, they challenge both contemporary claims that these particular medical borders could protect British bodies, and abiding presumptions that medicalised borders in general were, are, or can be epidemiologically effective or politically neutral.

The first case, that of a Pakistani man, M.A., reveals the extent to which procedures at the geographical medical border deviated from (admittedly fluid) immigration policy and presumed professional norms.⁴² It also demonstrates that medical evidence, prized as definitive by non-medical authorities, was often far from conclusive or neutral. M.A. sought to enter Britain as a work-voucher holder in May 1965. As a primary migrant, he was referred to the airport

Medical Inspector, inspected visually, tentatively certified as suffering from primary syphilis, and sent to a local NHS hospital for further examination. On his return to the airport, the Chief Immigration Officer refused M.A. entry on medical grounds and returned him to Pakistan. He had been detained nearly five hours longer than the primary legislation allowed.

Had M.A. been removed from the country in under twenty-four hours, or had he simply accepted the decision, this Report of Refusal would have remained as apparent evidence of the effective and correct application of CIA62's medical provisions.⁴³ But those extra hours meant that immigration officials were required to inform the Pakistan High Commission (its UK embassy) of M.A.'s detention, exposing the weak clinical case, and prompting M.A.'s UK-based brother, S.A., to contest it through a solicitor.

In particular, they questioned the 'alleged medical grounds' for M.A.'s deportation: M.A., they reported, had been medically examined on his return to Pakistan, and diagnosed with 'a mosquito bite'.⁴⁴ Their challenge promoted consternation in the Home Office and eventually, consultation with the Ministry of Health. Beneath an unruffled surface, the Ministry of Health moved from initial certainty of its Medical Inspector's diagnosis through to anxious confidence – 'I could not find details ... but it *seems* that he had syphilis confirmed by investigations'⁴⁵ – to a flat internal rejection of the 'rather flimsy' grounds for refusal.⁴⁶ Yet medical officialdom remained committed to the refusal itself. Right or wrong, border medical assessments were upheld, to 'preserve the right to examine' at the geographical border.⁴⁷

In part, the Ministry's internal debate about the validity of M.A.'s refusal reflected a perennial weakness of medicalised borders: the pace of medical change. In this case, definitive diagnosis was hindered by rapidly changing standards of medical proof, as an increasing number of competing diagnostic procedures and tests emerged. Crucially, whether for TB or VD, none could swiftly exclude infection. As one Ministry of Health official grumbled in the M.A. case, 'if medical clearance of this sort is required, immigrants must be kept available ... for adequate tests to be performed'.⁴⁸ Yet the primary legislation itself derailed any such detailed examinations of incoming migrants, even if, as in M.A.'s case, scarce NHS resources were expended on screening.

If medical screening to exclude venereal disease was too slow for border procedures, conclusive screening to exclude tuberculosis there was nearly impossible. Here, concerns about the expertise and honesty of medical certifiers abroad were concatenated by heated UK debates about the rate and origins of TB among migrants, what constituted 'cured' tuberculosis, and the level of 'threat' posed even by clearly infected migrants to the wider community.⁴⁹ Cases centred around tuberculosis, including the one explored below, also demonstrate the efforts of migrants and their allies to limit or control their exposure to the vagaries of the medical border; and emerging tensions between the Ministry of Health and Home Office about the operation and especially the desired *outcomes* of the medical border.

By 1966, would-be immigrant M.L.C. from Hong Kong was clearly aware of the unpredictable system that would determine his fate at the British border. In his village, migration to the UK was common and first-hand information about the UK system of medical control was widely shared. Eager to take charge of his future, M.L.C. wrote to a British Member of Parliament, Hong Kong-born Jeremy Bray, seeking reassurance that his cured tuberculosis would not precipitate a medical refusal. He was 'desperate' to migrate, refusal would be 'disastrous', and he feared the uncertainty of the UK's medical border.⁵⁰ Such fears did not, as some in the Ministry of Health had hoped, have a 'deterrent effect' on this migrant.⁵¹ Rather, they prompted determined efforts to navigate the system. Sadly for M.L.C., Bray could do nothing; the Home Office jealously preserved its Immigration Officers' rights to demand border medical inspections, even of migrants certified abroad as healthy.⁵²

It is notable, of course, that the Immigration Officer was the decision-maker. Immigration officers were not medically qualified or trained to spot signs of ill health. Thus only suspicion, rather than clinical expertise, could inform their decisions to send migrants for medical exams. As would become ever more evident, border medical examinations did not operate as the 'health checks' initially envisioned – clinical measures intended to protect the nation from disease and the NHS from expense. Instead, they were already becoming a biomedical addition to the Home Office's surveillance machinery.⁵³

While the Home Office clearly regarded racialised migrants and their foreign doctors as inherently suspect, the Ministry of Health had

other, equally intractable, concerns. Tuberculosis was complicated, and the diagnostic tools available to border officers were inadequate. As one medical officer explained, certifying a patient as TB-free really required radiological surveillance over a period of months.⁵⁴ Clearly, this was not obtainable at the border, nor was it a reasonable standard of proof to expect of voucher holders and their dependants coming from nations without advanced medical infrastructure. Under such conditions, and given wider suspicions of medical expertise abroad, he argued that overseas certificates, capturing only a single clinical datum, offered 'very little assurance ... at a port of entry.'⁵⁵

It is also worth noting that the experimental X-ray scheme which threw up these complicated TB cases was explicitly instituted to identify and quantify, rather than to exclude tuberculosis cases.⁵⁶ Only the most clear-cut cases of active infection were to be refused. Otherwise, all were to be landed while the films were sent to a specialist for assessment. Any cases of TB later identified would be notified to the Medical Officer of Health in the migrant's 'port of arrival', where migrants could be assessed and treated as normal via the NHS.⁵⁷ In fact, from the point of view of the Ministry of Health, the principal public health benefit of port radiographic screening was its potential to improve medical surveillance at the internal border: 'what really matters is to get the immigrant and their families ... involved with the health service as soon as possible after arrival.'⁵⁸ Yet clearly, only months after it was initiated, the scheme was already morphing from a fact-finding to an exclusionary apparatus.

Of course, these cases challenge rhetorical claims that the medical exclusion of otherwise eligible British subjects was intended solely to protect the public from 'the categories [of immigrants] we know to be dangerous to public health'.⁵⁹ None of the Ministry's medical experts argued that M.L.C. or M.A. were 'dangerous' to others. Instead they referred to signs of *possible* ill health that might require costly NHS treatment. Officials at the Ministry of Health were well-aware that no regime of medical inspection at the border could guarantee the exclusion of diseases such as tuberculosis or syphilis. Meanwhile for the Home Office, medical opinions and evidence were merely tools with which to defend contested immigration refusals.

Medicalised but not healthy: UK border controls 1969–1981

From the late 1960s through the 1970s, pressure mounted on those agencies charged with controlling entry at Britain's borders. Growing evidence of popular racism, combined with ever louder calls for effective immigration controls, prompted new measures intended to further restrict immigration from the New Commonwealth. On the heels of the 1965 White Paper on Immigration's equation between healthy 'race relations' in Britain and tightly restricted immigration came growing panic that the processes of 'Africanisation' and emerging anti-Asian sentiments in the newly independent nations of British East Africa would spark uncontrollable mass migration of affected populations to the United Kingdom.⁶⁰ The disgraceful result was CIA68, specifically designed to remove the right of Kenyan Asians to enter Britain, while protecting the rights of white colonial populations by privileging those with a 'qualifying connection' with the British Isles.⁶¹ The Act was followed by new guidance for Immigration Officers, forcefully encouraging all dependants seeking to enter the UK to gain an entry certificate before leaving their countries of origin. It mandated that those seeking settlement do so. The 1969 Appeals Act made entry certificates mandatory for all Commonwealth migrants; moreover, only certificate holders acquired the right to appeal granted by the new legislation.⁶² Entry certification required both identity and health checks; as we will see, these two processes were almost immediately conflated in practice.

The 1971 Immigration Act further tightened restrictions on migration from the New Commonwealth and put them on the same footing as aliens. The Act was structured to virtually end the primary migration for work of all non-Europeans without professional qualifications. It provided the basis of UK immigration policy and practice until BNA81 amended it. Even after 1971, the spouses of resident primary migrants and their children up to age 18 remained legally exempt from exclusion on health grounds. However, since they could be admitted subject to medical conditions enforceable at Britain's internal medical border, the new instructions for UK Immigration Officers recommended that all dependants be referred for medical inspection on entry.⁶³ In practice, medical inspection regimes at both domestic levels were far from

comprehensive, vitiating the protective powers expected of the 'health checks' by legislators and the public. However, their inability to protect public health from the (scant) risks presented by inward migration did not affect their exclusionary function, particularly as medical examination expanded at the external border.

For a decade after 1971, immigration law remained relatively stable. During this period, practices at all three of Britain's medical borders – internal, geographical and external – came under increasing scrutiny from a variety of angles. Abroad, chronic understaffing and ever tightening 'guidance' for entry clearance officers in migrant-sending nations rapidly led to embarrassing 'queues' of would-be migrants and increasingly exclusionary practices, both medical and administrative. In Britain, anxieties about compliance with Race Relations laws, a continuing shortfall in funding for migrant integration programmes (including public health), and growing activism among and around established ethnic communities combined to produce great variability in the operations of the 'port of arrival' system. Yet at the UK's geographical border, medical procedures apparently remained static and largely invisible until, as will be discussed below, they were exposed in 1979 under the glare of media attention.

So did these shifts substantially intensify the medicalisation of Britain's borders? Yes and no. After 1968–69, many more would-be migrants were subjected to medical screening, particularly through the entry certification process.⁶⁴ As DHSS files repeatedly reported, from a health perspective, such medical examinations varied in quality and detail and offered numerous opportunities for error and subversion.⁶⁵ Instead, it was an unintended consequence of the expanded entry certificate regime that would prove the most impactful, by bringing 'entitled' dependants under biomedical surveillance not to assess their health, but to test claims about their identity and entitlements.

Examined for exclusion: undermining 'entitlement' at the medical borders

As Henry Yellowlees, CMO from 1973 to 1984, would later complain of Britain's medicalised borders, 'The kind of medical

examination applying ... is determined ... not so much by health criteria but more by the individual's immigration category.⁶⁶ For example, from the late 1960s, entry clearance officers in some New Commonwealth nations – particularly Pakistan and Bangladesh where state record keeping was notoriously scanty – routinely used radiography to check the ages of dependants where the documentary evidence was deemed insufficient or unreliable. Costs for such examinations and the associated expense of travelling to often distant medical facilities added another barrier to migration for many.⁶⁷

Clearly, then, the effort by UK authorities to create a medical border abroad increased the cost and decreased the freedom even of entitled dependants to migrate. The medicalisation of Britain's external border, like the medicalisation of its domestic borders, was officially enacted to prevent the importation of disease and reduce domestic fears of infection that were seen as one factor in the growth of racism. However, it was *used* to enable the collection of biological data not about health status, but about identity. Rather than an aid to the inclusion and integration of legal migrants, it became a tool to enable their exclusion.

The fact that these medicalised controls received relatively little critical attention from state bodies investigating Britain's new immigration procedures reveals the continued persuasive power of medical claims to produce authoritative and objective knowledge about human bodies. In the late 1960s and 1970s, members of the Select Committee on Race Relations were tasked with assessing whether Britain's border practices complied with UK Race Relations legislation. They toured British High Commissions around the world, as well as UK ports and airports, seeking evidence and questioning the civil servants charged with managing migration. While Committee members routinely scrutinised the operation of the external medical border, the thrust of their questions was in general to test its rigour and efficacy in preventing disease importation, rather than its fairness. As the tenor of interviews with DHSS International Health Division staff makes clear, the Committee itself leaned strongly towards tightening medical controls on dependants, and applying them abroad, 'as other countries do'.⁶⁸ Even the testimony of the Joint Council for the Welfare of Immigrants [JCWI], highly critical of the new entry certification process and the actual and apparent racism that informed the 1968 and 1969 Acts, offered little criticism of the

health checks themselves. In the eyes of the JCWI, they were an insignificant barrier in comparison with the many other hurdles placed between Commonwealth dependent migrants and their legal entry to and residence in Britain (including the operations of the internal medical border, described by JCWI as the 'harassment of immigrant households by the public health authorities').⁶⁹

At the UK geographical border itself, the 1968, 1969 and 1971 extensions of the medical remit produced far less change, and little satisfaction for those intent on eliminating the importation of tuberculosis or other ill health. In fact, the new measures and instructions increased the challenges faced by medical border agents. With Commonwealth spouses, fiancé/es and minor children newly eligible for medical inspection, and widespread mistrust of health certificates issued in Pakistan, India, Nigeria and Cyprus, Port Medical Inspectors were empowered and eager to screen a growing number of entrants. But beyond Heathrow, they were unable to do so routinely, given the constraints that operated against off-site screening. Moreover, while secondary family-reunification migrants could now be medically screened, they still could not be refused entry and settlement on health grounds. Frustrated Medical Inspectors could only pass details of illness uncovered at the port of entry to the often overburdened health authorities at migrants' destinations. These addresses were notoriously insufficient, transient and erroneous, rendering contact tracing and medical follow-up all but impossible. In 1968, of the 42,124 advice notes alerting local medical officers to the arrival of new migrants, only 24,501 were successfully visited.⁷⁰ In the same year, of the 537,405 Commonwealth persons arriving at British ports and airports, 53,327 were medically examined, but only 59 were refused on medical grounds.⁷¹

By 1970, as the new rules bedded in, the DHSS could report that virtually all entitled dependants entering the UK through Heathrow – at this time approximately 90 per cent of such migrants – were 'medically examined'. However, only some 9 per cent were X-rayed. Detailing the procedures he observed at Heathrow, unchanged even a decade later, Britain's Deputy Chief Medical Officer, Dr N. John Evans expressed the long-held DHSS view: 'These arrangements fall very short of an effective *health* screen. They are more of a token than a real safeguard.'⁷² Yet despite the limitations – of time, personnel and technology – that hampered effective health examinations,

border agents commissioned some tests which offered no protection to the public; at least some passengers were transferred to a local NHS hospital to receive 'bone X-rays for age assessment'.⁷³ In other words, far from offering protection by border health screening, NHS resources being were appropriated for medicalised identity surveillance.

*Disputes at the frontier: medical controls
and the Yellowlees Report*

In 1979, Heathrow's medical border was suddenly exposed to public view by an international scandal. It was triggered by reporter Melanie Philips of the left-leaning *Guardian* newspaper. Philips reported that some female migrants – almost all of South Asian heritage, arriving as entitled fiancées, wives or even daughters – were subjected to 'virginity testing' at Heathrow Airport.⁷⁴ This involved genital examinations described by affected women themselves as an exercise in humiliation. Girls and women had their pubic hair shaved and were internally examined, often by male medical staff 'chaperoned' by male interpreters, for evidence of prior sexual intercourse or childbirth, or to assess their age.⁷⁵

Rendered visible by an unusual combination of journalistic scrutiny, direct testimony, and Parliamentary inquiry, Heathrow's medical controls demonstrated the paradox of Britain's invasive and yet porous 'health' border; medical procedures which were manifestly unfit for their supposed public health purposes were instead harnessed by the Home Office to serve an exclusionary agenda. The legal powers, time and equipment granted to the port medical inspectorate were clearly inadequate to halt a (hypothetical) 'wave' of contagion from entering the country in the bodies of 'entitled' secondary migrants. Yet, as Evan Smith and Marinella Marmo have documented, their scope was (just) sufficient to enable unsavoury and unsound medical practices including both 'virginity testing' and radiographic 'age assessments' of would-be child migrants.⁷⁶

By comparing Home Office and DHSS responses to the scandal, a key shift becomes clear. The UK's tripartite medicalised border was neither the universal exclusionary 'health check' long sought in vain by medical professionals, nor the looser form of border surveillance and risk-based contact tracing deemed practical and achievable by

the Ministry of Health and its successors. Instead, physical and radiographic examinations at the geographical border were used selectively to support efforts to exclude otherwise 'entitled' racialised migrants for failing to meet biologised criteria such as age limits, or (for women) presumed cultural expectations about sexual behaviour.⁷⁷ These facts were known at Whitehall; the ensuing scandal simply exposed them to a much wider public.

Controversially, the DHSS report responding to the 'virginity testing' crisis – known popularly as the *Yellowlees Report* – forcefully recommended the comprehensive exclusionary screening of all migrants in countries of origin. Only such controls, applied to existing 'entitled' as well as new primary migrants, could truly protect Britain's medical border and 'the health and financial interests of those already in the UK.'⁷⁸ Yellowlees acknowledged that a retroactive 'health bar' on the dependants of settled migrants might be criticised as 'morally undesirable or politically injudicious', but he was only prepared to offer deferred entry – post-treatment – to such entitled migrants.

It is in Home Office responses to the *Yellowlees Report* that the final set of tensions which explain the abiding porousness of the UK's medical borders become clear. As Smith and Marmo have shown, the Home Office was deeply committed to, and deeply unapologetic for operating a *racially* discriminatory immigration system. As one official asserted in an internal memo, 'Migration is essentially a racial matter and the only basis on which the periodic migrations to which all peoples are subject can be regulated, is by numbers according to race.'⁷⁹ However, neither Home Office civil servants nor its Minister, Willie Whitelaw, had any intention of accepting Yellowlees' calls for a *medically* discriminatory border. Yellowlees expressed his view that all medical procedures should be applied only to serve the domestic disease prevention agenda and to preserve NHS resources. This was certainly the established popular understanding of the checks, and the rationale for their inclusion in successive Immigration Acts. However, this was far from the Home Office view. In fact, they were furious that he had used the pretext offered by the scandal to air the Department's long-silenced frustrations with existing health controls.⁸⁰ Internally the Home Office admitted that, from their perspective, the examinations in question 'are not concerned with the health of the person examined ... they

are directed to producing answers to what are non-medical questions.⁸¹ As in the past, the Home Office sought putatively objective and irrefutable medical evidence to constrict migrants' rights and withstand their legal appeals.

The DHSS had long resented providing such leverage.⁸² As they had since the 1960s, the medical professionals in the DHSS resisted politicisation of their remit, irrespective of their views on 'race' or migrants' rights. Political colonisation of medical expertise undermined the Department's ability to act in accordance with their own professional commitments to what they saw as 'objective' medical evidence. As Dr N. John Evans – whose drafting of the 1980 *Yellowlees Report* offered few signs of liberality – insisted: 'the racial or ethnic characteristics of a migrant ... are not a medical matter, still less a medical problem'. 'Health controls', he emphasised, 'are not a surreptitious way of discriminating for or against particular classes of immigrants and must not be allowed to become so'.⁸³ Yet, of course, questions of immigrant health were deeply political, particularly as the racist and anti-immigrant British National Front had recently attacked migrants by deploying explicitly medical claims and anecdotes.⁸⁴

Fear that publication of the *Yellowlees Report* would have 'disastrous' effects on race relations in the UK triggered a dazzling display of institutional cognitive dissonance at the Home Office. Bureaucrats who urgently sought medical evidence to exclude racialised family reunification migrants nonetheless dismissed *Yellowlees'* focus on disease (and cost) prevention as 'much too narrow' and – in light of international considerations – as 'selfishness of a high order'.⁸⁵ Condemning the Report, the Home Office ironically reverted to the enduring discourse of the UK's humanitarian and ethical responsibilities to its Commonwealth.⁸⁶ In particular, the Home Office leveraged both the success of the NHS and its dependence on migrant professionals to excuse border practices which impeded the free movement of entitled but unwanted migrants, but could not prevent the importation of disease. Contrasting the UK's advanced health services with service provision in migrants' countries of origin, the Home Office correctly (if disingenuously) contended that admitting Commonwealth medical migrants while enforcing health barriers against their co-nationals constituted: 'consigning to greater disadvantage those who are

disadvantaged already' while 'weakening further the[ir] health services'.⁸⁷

Despite the active efforts of Home Office immigration officers at the geographical border, and Foreign and Commonwealth entry clearance officers at its external equivalent to medicalise disputes about access to the UK, they feared the effects of 'the medical factor' introduced by the DHSS.⁸⁸ As a result, the *Yellowlees Report* was never formally published. Its recommendations for the mandatory medical examination of all dependants at origin, and for the deferred entry or outright exclusion of those judged to be unwell found no place in BNA81. Not until 2005 would such an approach be instituted in law.

Conclusions

Only after World War II did the UK gradually begin to erect medical borders analogous to those long established in its former colonies and dominions, and by the USA. Despite popular and professional enthusiasm for strong health controls, a range of factors worked against their implementation. As a former imperial power, Britain's legal powers to close the 'open door' offered to its far-flung subjects were initially limited. Moreover, labour shortages, economic and cultural ties, national commitments to economic and social liberalism, and a desire to maintain Britain's international influence all initially militated for relatively open borders. Medically, too, instituting effective health controls seemed both impractical and uneconomic. The migrants posed little threat of disease, border screening was costly, and the availability of the NHS allayed experts' concerns about transmission of 'imported' disease to local communities, if not about cost to the health services. Moreover, continued support for family reunification on humanitarian grounds also meant that, by the late 1960s, the bulk of migrants were the wives and young children of men already established in the UK, who could not be excluded on health grounds, making investment in border health controls largely pointless.

These factors did not prevent a gradual medicalisation of Britain's borders. The effects of this process were most visible at the UK's externalised borders in Commonwealth migrants' countries

of origin. Here, biomedical processes initially intended to assess the health and productive capacity of labour voucher applicants were relatively quickly extended in the search for robust evidence justifying the exclusion of otherwise entitled secondary migrants. Internally, the ability to apply medical conditions to the admission of entitled migrants had more variable effects, depending on their locations and the levels of commitment, funding and cultural sensitivity offered to the 'port of arrival' system by local health authorities. At the UK's geographical border – its ports and airports – however, medicalisation proved partial, perfunctory, controversial when exposed to public scrutiny, and ultimately ineffective. Practical and political constraints consistently outweighed health concerns and, between 1962 and 1981, medical refusals at the border were rare, even when public anxieties about immigrant health were highest.

So how was the shift to mandatory health screening in 'high risk' nations – so long the goal of the UK's health authorities – eventually enabled? After the Cold War, political sensitivity to global (but not national) 'race relations' declined, and the Commonwealth was devalued as vehicle for political influence. A series of 'asylum crises' in the late twentieth century refashioned migration as 'uncontrolled' and 'uncontrollable', in the process, revisiting and revivifying narratives of migrants as burdens on a threatened NHS. Resulting legislation placed more migrants into 'controlled' categories, rendering them available for medical sanction and at least temporary exclusion. The expansion of the European Union similarly expanded what were perceived as 'uncontrollable' economic migrants. At the same time, British authorities gained increased confidence in the reliability and sensitivity of medical testing abroad, as medical expertise in migrant-sending nations developed and could be co-opted. Finally, with the virtual disappearance of TB from Britain's ethnic majority population, a medical consensus emerged that the condition was 'imported', and thus could be excluded. The ability to outsource screening to international agencies, and to impose the costs of that service on migrants themselves made such exclusion economically appealing. In the end, tensions between 'traditions of tolerance' and 'deep-seated prejudices' both at the borders and in the NHS created opportunities for migrant health screening, but also limited its exclusionary effects and rendered it 'suspect'.

Notes

- 1 H. Gans, 'Racialization and racialization research', *Ethnic and Racial Studies* (2016) DOI: 10.1080/01419870.2017.1238497; K. Murji and J. Solomos (eds), 'Introduction: racialization in theory and practice', in *Racialization: Studies in Theory and Practice* (Oxford: Oxford University Press, 2004), pp. 1–28.
- 2 W. Webster, 'The empire comes home: commonwealth migration to Britain', in A. Thompson (ed.), *Britain's Experience of Empire in the Twentieth Century* (Oxford: Oxford University Press, 2012), pp. 122–60.
- 3 The term 'subject' is an important one in the UK context, where an exclusive national citizenship emerged slowly. Until 1948, all persons born within the British Empire were classified not as 'citizens' but as 'subjects' of the British crown. Unlike 'citizenship' in which citizens both acquire and can claim *reciprocal* rights through their membership in a given community, the privileges of 'subjecthood' are unilaterally granted by the monarch, against whom claims cannot be made. Only through the 1948 British Nationality Act did Parliament grant individuals born within the empire a 'citizenship' linked to their British subjecthood, and it too was tied to the Commonwealth. 'British citizenship' was defined only in 1981. See R. Hansen, *Citizenship and Immigration in Post-War Britain: The Institutional Origins of a Multicultural Nation* (Oxford: Oxford University Press, 2000), especially pp. 35–45.
- 4 On the 'port of arrival' system see J. Welshman, 'Compulsion, localism, and pragmatism: the micro-politics of tuberculosis screening in the United Kingdom, 1950–1965', *Social History of Medicine*, 19:2 (2006), 295–312; R. Bivins, *Contagious Communities: Medicine, Migration, and the NHS in Post-War Britain* (Oxford: Oxford University Press, 2015), pp. 168–266. On hygienic citizenship, see W. Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham, NC: Duke University Press, 2006), pp. 180–207; A. Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism, and Public Health* (Basingstoke: Palgrave Macmillan, 2003), pp. 79–80.
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- 6 See, for example, The National Archives, London [TNA], MH58/671, MH148/30.
- 7 C. Cox, H. Marland and S. York, 'Itineraries and experiences of insanity: Irish migration and the management of mental illness in nineteenth-century Lancashire', in C. Cox and H. Marland (eds), *Migration, Health and Ethnicity in the Modern World* (Basingstoke: Palgrave Macmillan, 2013), pp. 36–60 at pp. 38–40.

- 8 K. Maglen, "The first line of defence": British quarantine and the port sanitary authorities in the nineteenth century', *Social History of Medicine*, 15:3 (2002), 413–28 at 413.
- 9 K. E. Collins, *Be Well! Jewish Health and Welfare in Glasgow, 1860–1914* (East Lothian: Tuckwell Press, 2001), pp. 97–112, quoted in K. Maglen, 'Importing trachoma: The introduction into Britain of American ideas of an "immigrant disease," 1892–1906', *Immigrants & Minorities*, 23:1 (2005), 80–99; J. Pellew, 'The Home Office and the Aliens Act 1905', *Historical Journal*, 32:2 (1989), 369–85.
- 10 Aliens Act 1905, p. 5 at www.legislation.gov.uk/ukpga/1905/13/pdfs/ukpga_19050013_en.pdf (accessed: 1 December 2017).
- 11 Aliens Act 1905, p. 7.
- 12 Aliens Act 1905, p. 4.
- 13 B. Taylor, 'Immigration, statecraft and public health: the 1920 Aliens Order, medical examinations and the limitations of the state in England', *Social History of Medicine*, 29:3 (2016), 512–33.
- 14 Hansen, *Citizenship and Immigration*; R. Karatani, *Defining British Citizenship: Empire, Commonwealth, and Modern Britain* (London: Routledge, 2003), pp. 153–4; J. Tomlinson, 'The Empire in economic thinking', in Thompson, *Britain's Experience of Empire*, pp. 211–50.
- 15 H. Hopkinson, 'Colonial immigrants' *Hansard*, Commons Deb 05 November 1954 vol. 532. cols 821–32 at 827–8.
- 16 See, for example, J. Hynd, 'Colonial immigrants', *Hansard*, Commons Deb 05 November 1954 vol. 532. cols 821–32 at 822–3.
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- 18 See E. Hess and N. MacDonald, 'Pulmonary tuberculosis in Irish immigrants and in Londoners: comparison of hospital patients', *Lancet* (17 July 1954), 132–6; N. Macdonald, 'West Indian settlers responsibility of Great Britain', *The Times* (12 November 1954), p. 9.
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- 21 *Commonwealth Immigrants Act 1968*, p. 2.
- 22 Bivins, *Contagious Communities*, pp. 115–67.
- 23 TNA, MH55/2276, Minutes, 'The medical examination of immigrants' Meeting between Ministry of Health and Association of Municipal Corporations, 11 December 1957.
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- 29 See Bivins, *Contagious Communities*, pp. 177–8.
- 30 TNA, MH55/2632, B. D. Fraser to E. Powell, 14 March 1962.
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- 32 TNA, MH148/29, H. N. Roffey to Hill (Ministry of Aviation), 15 November 1963.
- 33 TNA, MH55/2632, G. Godber to B. D. Fraser, 7 February 1962.
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- 35 TNA, MH55/2632, B. D. Fraser to E. Powell, 14 March 1962.
- 36 TNA, MH148/28, K. B. Paice to H. N. Roffey, 26 August 1963.
- 37 TNA, MH148/28, R. Wood to H. N. Roffey, 16 August 1963.
- 38 TNA, MH148/28, H. N. Roffey to Pater, 12 September 1963.
- 39 TNA, MH148/28, Lord Newton to E. Powell, 19 September 1963.
- 40 TNA, MH148/29, Memo, E. M. Atter to H. N. Roffey, 19 May 1964.
- 41 See 'BMA seek health check on immigrants before entry', *The Times* (3 December 1965), p. 7.
- 42 The case files include the full names of their subjects; here, I use initials to protect the identities of the individual migrants.
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- 49 See Bivins, *Contagious Communities*, pp. 21–61, 168–226.
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- 52 See extended correspondence on file TNA, MH148/37.
- 53 TNA, MH148/37, Home Office to J. Bray, 26 May 1966.
- 54 TNA, MH148/37, A. J. Eley to H. N. Roffey, 23 May 1966.
- 55 TNA, MH148/37, A. J. Eley to H. N. Roffey
- 56 TNA, MH148/28, Pater to Godber, 20 September 1963.
- 57 TNA, MH148/28, 'Medical Examination of Immigrants'.
- 58 TNA, MH148/28, Memo to Pater, 30 September 1963.
- 59 TNA, MH148/27, C. R. O. Jones, 'Medical Examination of Immigrants', 1 January 1963.
- 60 For detailed analysis of these shifts, see Hansen, *Citizenship and Immigration*, pp. 153–243; Karatani, *Defining British Citizenship*, pp. 145–80; E. Smith and M. Marmo, *Race, Gender and the Body in British Immigration Control: Subject to Examination* (Basingstoke: Palgrave Macmillan, 2014), pp. 22–74.
- 61 A 'qualifying connection' (later 'patrality') was defined as having either personally or through parental or grandparental descent been born, adopted, registered or naturalised in the United Kingdom. Karatani, *Defining British Citizenship*, pp. 158, 162.
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- 64 TNA, HO418/33, Henry Yellowlees, *The Medical Examination of Immigrants* [hereafter *Yellowlees Report*], 22 April 1980, p. 2.
- 65 See for example, TNA, MH154/1510, J. R. Reid, 'Tuberculosis and Immigrants: Draft Paper for the Home Office', 29 April 1976.
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- 73 *Yellowlees Report*, p. 20.
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- 76 Smith and Marmo, *Race, Gender and the Body*, pp. 75–101.
- 77 Smith and Marmo, *Race, Gender and the Body*, pp. 75–134, 149–74. For a flavour of public and professional concern, see J. Galloway, 'Immigration and the M.O.H. – A retrospect', *Public Health*, 86 (1972), 83–8; 'Tuberculosis retreats – slowly', *Lancet*, 303:7866 (1 June 1974), 1087–8; 'Migrants admitted with TB', *Daily Telegraph*, 8 September 1976.
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- 81 TNA, HO418/33, G. I. de Deny to P. J. Woodfield, 17 July 1980.
- 82 See TNA, MH154/1510, 'Health Control Arrangements', 1976.
- 83 *Yellowlees Report*, p. 31.
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- 85 TNA, HO418/33, P. J. Woodfield to J. F. Halliday, 26 June 1980; and G. I. de Denny, 'Medical Examinations' 16 May 1980.
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- 87 TNA, HO418/33, G. I. de Denny, 'Medical Examinations', 16 May 1980.
- 88 TNA, HO418/33, 'Medical Examinations'.