Politics of Care in the NHS: Navigating Immigration Enforcement at the Clinical Frontline

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Abstract

As part of the UK's "hostile environment" agenda, individuals who are not deemed "ordinarily resident" within the state are subject to fee-charging and data-sharing practices when accessing secondary healthcare. The introduction of these policies sparked significant backlash, leading to the emergence of activist organisations such as *Patients Not Passports* and *Docs Not Cops*. Formed in direct response to the legislation, these groups challenge the ethical legitimacy of the policies, arguing that they infringe upon core clinical principles and compromise the integrity of care.

This thesis draws on semi-structured interviews with NHS doctors and participant observations of *Patients Not Passports* meetings to explore how clinicians navigate hostile environment policies in their everyday practice. It delves into the ethical dilemmas that arise at the intersection of healthcare and immigration enforcement, examining how doctors deploy discretion to reconcile professional obligations with the demands of these policies.

The analysis is framed through the lens of street-level bureaucracy, using discretionary practices as a conceptual tool to understand how policy is negotiated in practice. Findings reveal that discretion is frequently exercised as a form of quiet resistance, rejecting or circumventing policy directives on moral grounds. Clinicians consistently expressed that these policies conflicted with their ethical commitments and the founding principles of the NHS, placing them in profound moral dilemmas. Many aligned their personal values with the ethos of the NHS, prioritising care and equity over compliance. Their responses reflect a deep tension between institutional expectations and professional ethics.

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Table of Contents

Introduction

A 2012 interview conducted by the Telegraph of the then Home Secretary Theresa May saw the introduction of what came to be known as the ‘hostile environment’ policy in the interview she shared that her role as Home Secretary “was to create here in Britain a really hostile environment for illegal migration”. Whilst the plan to create a hostile environment was not outlined in the traditional manner of a formal white paper (Grierson, 2018), it was implemented in a series of legislations including the Immigration Act of 2014 and the Immigration Act of 2016, with the primary objective is to restrict access to essential public services and opportunities, such as housing, education, employment, and healthcare (Taylor, 2018).

A year after May's interview, the Home Office's Enforcement Directorate established the Interventions and Sanctions Directorate (ISD). Information obtained through a Freedom of Information request revealed that the ISD is responsible for implementing the hostile environment policy. It collaborates with various government departments and both public and private sector partners to restrict access to benefits and services for irregular migrants and enforce sanctions (WhatDoTheyKnow, 2013). This period was marked by a heightened focus on immigration control and a political climate increasingly concerned with reducing illegal migration. Four months later, a new Immigration Bill was introduced to formalise this approach, becoming the Immigration Act 2014, which was later strengthened and expanded by the Immigration Act 2016.

One notable measure to encourage voluntary departure involved posters with the message "In the UK illegally? GO HOME OR FACE ARREST," displayed on vans in ethnically diverse London neighbourhoods and various community spaces, commissioned by the Home Office (Griffiths and Yeo, 2021).

The Immigration Act of 2014 delegated border control responsibilities to landlords, bankers, and marriage registrars, requiring them to check the immigration status of their clients (Immigration Act 2014). Additionally, the Act implemented an annual surcharge ranging from £150 to £200, along with additional fees for accessing accident and emergency services and certain primary healthcare services, excluding general practice. Critics argue that this has led

to increased racial profiling and discrimination (Griffiths and Yeo, 2021). The Immigration Act 2014 became controversial as it removed key protections for Commonwealth citizens from the 1999 Asylum Act, contributing to the Windrush scandal (Taylor, 2018).

Overall, the UK's expansion of border enforcement strategies aimed to deter illegal residency and restrict migrants' access to essential services, employment, and housing. Griffiths and Yeo (2021) term this approach as the 'deputisation' of immigration control, where the implementation of immigration policies is delegated to various actors such as public servants, healthcare professionals, private companies, and ordinary citizens. In the healthcare sector, regulations enforcing upfront charging of 150% for ‘non ordinary residents’ were introduced, and identification checks were mandated for patients seeking non-emergency hospital care (Potter, 2017). Additionally, a memorandum of understanding between the Department of Health, NHS, and Home Office facilitated the sharing of non-clinical data to aid immigration enforcement.

Griffiths and Yeo’s, 2021 study found that this deputisation resulted in third parties conducting discriminatory checks and imposing restrictions based on ethnicity to avoid penalties, adversely affecting both migrants and lawful UK residents from minority ethnic backgrounds. They concluded that as a consequence, the hostile environment fosters structural racism by promoting racial profiling through discriminatory checks against those perceived as 'foreign looking' (Griffiths and Yeo, 2021). They further state that ethnic minority groups have been disproportionately subjected to immigration checks and denied access to basic services including healthcare.

Whilst studies by the likes of Griffiths and Yeo have been vital in exposing the impacts of hostile environment policies, particularly on migrants, a noticeable gap in the literature exists when it comes to those expected to enforce these policies. Nearly a decade on from their introduction, and even with a shift from a Conservative to a Labour government, these policies are still being enforced. This thesis aims to understand how clinicians felt about them, and more importantly, how they navigated them in practice.

I was eager to explore the attitudes of NHS doctors towards hostile environment policies and how these attitudes influence their professional practice. That includes looking at how doctors interpret, negotiate, and respond to the ethical and procedural tensions these policies introduce into their everyday clinical work. This curiosity led to the following research questions, which guided the thesis:

RQ: How do NHS doctors navigate hostile environment policies in their everyday clinical practice?

Sub RQ1: What ethical dilemmas arise for doctors when navigating the intersection of healthcare and immigration enforcement?

Sub RQ2: What strategies do doctors employ to reconcile professional obligations with the demands of hostile environment policies?

Sub RQ3: How do institutional constraints and personal values shape the way doctors interpret and respond to these policies?

The study draws on accounts from five doctors based in South Wales, gathered through semi-structured interviews, alongside participant observations of meetings held by Patients Not Passports, a collective of practising NHS clinicians campaigning against immigration controls in healthcare.

The thesis explores ethical dilemmas through the cases and experiences shared by interviewees, paying attention to how their ethics are shaped by alignment with NHS principles. The main focus is on navigation and strategy, how doctors respond to policy demands in practice. This thesis utilises the theoretical lens of street-level bureaucracy, with a focus on discretion. Within the thesis discretion is explored as a form of ethical judgement, a coping mechanism, and a way of managing bounded rationality. The thesis looks at both concealed and transparent forms of discretion, including cases where doctors have openly used their discretion to oppose hostile environment policies.

Contextual Background

NHS Digital

The practice of sharing information between departments for immigration enforcement under the hostile environment plan was also implemented in the healthcare sector. This became particularly controversial when it was revealed that NHS Digital had agreed to share patient information with the Home Office to identify immigration offenders. A memorandum of understanding published in January states that NHS Digital must provide the Home Office with information about patients suspected of committing immigration offences (Home Office, Department of Health, 2017). This includes individuals who have absconded from immigration control, escaped detention, or overstayed their permitted duration in the UK.

NHS Digital will not share clinical information but will provide details such as a patient's last known address, date of birth, full name, and date of NHS registration. The memorandum claimed that this information is less intrusive, making it easier to justify disclosure as the public interest threshold is lower. The Home Office uses this information to encourage offenders to return home by denying them access to benefits. In more serious cases, they will arrest, detain, or deport them.

Whilst this was a new agreement, the Home Office has been requesting data from the NHS on migrants since at least 2005. Previously, the Home Office had to request this information directly from GPs, who often refused to share it (Gulland, 2017). Now, NHS Digital will provide the information directly, bypassing GPs. In the first 11 months of 2016, the Home Office made 8127 requests for data, leading to 5854 people being traced by immigration enforcement. This is a significant increase from 2014, when there were 725 requests in the first three months compared to 2244 requests in September and October 2016 (NHS, Digital). Before January 2017, NHS Digital could only identify the region where a patient was registered, requiring the Home Office to contact local NHS organisations to obtain contact details (Gordon, 2017). This process involved multiple steps and coordination among various parties using different systems. The memorandum of understanding aimed to streamline this procedure by enabling NHS Digital to directly trace and provide the individual's personal data to the Home Office, eliminating the need to contact local NHS bodies for information (Gordon, 2017).

Organisations such as Doctors of the World, the National Aids Trust, and the British HIV Association had expressed concerns, stating that the agreement intrudes on how medical records are kept and safeguarded. This could lead to dangerous situations and increased reliance on emergency departments. Studies have shown that the threat of deportation is a significant barrier to seeking healthcare, as evidenced by research in the United States, concerns about disclosing undocumented status can lead to reduced or delayed health seeking behaviour for various illnesses, including tuberculosis (Asch et al., 1994; Martinez et al., 2015). In the UK, the fear of deportation similarly impacts the willingness to undergo testing for communicable diseases, such as HIV (Dodds et al., 2008; Thomas et al., 2010).

As the policy largely places responsibility on public service providers to liaise with the home office resulting in a transition of the role of the public service provider to one of that as 'border guards' (Lacobucci, 2018). A study conducted by Pierce & Adil (2025) into the

Effects of hostile environment policies on maternity care for refugees, asylum seekers, and undocumented migrants in Camden had concluded that the policies had “undermined their (healthcare workers) duty of care, personal morals, and the principles of the NHS” (Pierce & Adil: 1 2025). This discontent among healthcare workers was evidenced by campaigns and protests such as the #StopSharing campaign led by Doctors of the World, which garnered 71,000 signatures. Additionally, the formation of organisations like 'Docs Not Cops' sheds light on the widespread opposition to these policies within the healthcare community.

It's clear that the direct involvement of health professionals in enforcing the 'hostile environment' policy has co opted frontline NHS staff into implementing measures that undermine public health. Uthayakumar Cumarasamy (2020) points out that this approach implicates healthcare workers in a system that conflicts with their duty of care, straining ethical and professional boundaries. They argue that this policy agenda weaponises the NHS against society's most vulnerable groups, turning public sector workers into agents of structural violence. Placing health workers at the forefront of this harmful political discourse creates unsustainable tensions within their public duties. It disregards the values enshrined in the NHS Constitution, which outlines the responsibilities staff owe to each other and the public to ensure the NHS operates fairly (NHS Constitution for England, 2015). The universalism and equity that the NHS was built upon, and for which it is celebrated, are fundamentally incompatible with the hostile environment's contradictory and discriminatory policies. This reveals a deep conflict between the principles of the NHS and the demands of the hostile environment, highlighting the ethical dilemmas faced by healthcare professionals.

The Cost Recovery Programme

Disclaimer: This section draws extensively on the research conducted by the Institute for Public Policy Research (IPPR), (Morris and Nanda, 2021) and its references, which have provided detailed insights into the Cost Recovery Programme and associated charging regulations affecting asylum seekers and other vulnerable groups.

Another aspect of the hostile environment plan that gravely impacted asylum seekers' barriers to secondary healthcare was the introduction of charges for secondary healthcare under the NHS. In 2014, the Cost Recovery Programme was launched, followed by charging regulations in 2015 that increased healthcare fees for overseas visitors to 150% of the NHS national tariff. These changes also enforced stricter procedures for NHS providers to identify

and recover costs from patients. By 2017, new laws required upfront charging, as long as it didn't delay urgent or necessary treatment. The rules have become increasingly complex, with official guidance now exceeding 130 pages. Since the programme began, there's been growing evidence of its negative impact on the healthcare experiences of people living in England.

They also introduced new incentives and sanctions to encourage NHS providers to identify chargeable patients (House of Commons Library 2020). These measures were accompanied by provisions in the Immigration Act 2014, which introduced a health surcharge for temporary non-EEA migrants. The Act redefined ordinary residence to exclude individuals with limited leave to enter or remain, allowing the government to impose a health surcharge on those applying for limited leave to access the NHS freely (ibid). In 2017, the government amended the 2015 regulations to introduce upfront charging for people not ordinarily resident, provided it wouldn't prevent or delay urgent or necessary healthcare.

The 2017 regulations also extended charging to relevant community care services not directly provided by NHS bodies (ibid). Alongside these changes, the NHS increased its cooperation with the Home Office on charging and immigration matters. Since 2011, outstanding NHS debts of at least £1,000 have been grounds for refusal for applications to enter or stay in the UK. In 2016, these rules were tightened further to apply to outstanding debts of £500 (Home Office 2021a: paragraph 9.11.1). NHS providers were also required to notify the Home Office of debts of at least £500 where they had been outstanding for two or more months (for services provided on or after 6 April 2016) (DHSC 2019a). In 2019, it was revealed that Home Office immigration enforcement teams had used information on individuals with outstanding charges shared by NHS trusts to carry out immigration enforcement activities (ICIBI 2019).

A patient is considered ordinarily resident if all of the following apply (based on DHSC 2021):

- They are in the UK lawfully.
- They are in the UK voluntarily.
- They are in the UK for ‘settled purposes’ as part of the regular order of their life for the time being (this could be for a long or short duration).

- Where they are subject to immigration control, they have indefinite leave to enter or remain in the UK (or they are an EU/EEA citizen or family member with pre-settled status).

This definition excludes people residing in the UK without permission, including those who enter the UK through unauthorised routes, overstay their visa, or are refused asylum.

The charging regulations have led to significant delays in treatment for individuals subject to NHS charges, including those with serious and life threatening conditions (DOTW 2020a). Often, charges are imposed on those who cannot afford to pay, resulting in prolonged indebtedness (ibid). A recent survey of 200 child healthcare professionals revealed that about a third reported cases where the charges had negatively impacted patient care, including delays, refusals of treatment, and worsening health outcomes (Murphy et al 2020). Experts have also warned that the charging system poses a risk to public health in England. Evidence shows that individuals subject to charging, including those without immigration status, are hesitant to use NHS services due to fears of incurring large fees they cannot repay or having their data shared with the Home Office (DOTW 2017). This reluctance can even affect treatment for certain communicable conditions that are exempt from charging. A study on the impact of charging found an increase in delays in treating tuberculosis in non UK patients following the introduction of the Cost Recovery Programme (Potter et al 2020). Similarly, there is evidence that charging has deterred people with HIV from accessing healthcare, leading to delayed diagnoses (NAT 2021).

There are also concerns that the current NHS charging policy in England does not align with the UK's international commitments. In 2015, the UK adopted the United Nations' 2030 Agenda for Sustainable Development, which includes Sustainable Development Goal 3 on health and wellbeing. This goal aims to achieve "universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all" (UN). The current charging system falls short of this ambition, excluding individuals living in England without regular immigration status. Finally, it is unclear whether the recent healthcare charging reforms have been cost effective, considering the costs of delayed treatment and administering the system. NHS consolidated provider accounts indicate that NHS providers received only £35 million in cash payments in the financial year 2018/19, despite issuing invoices totalling £91 million (Waites 2019). In London, providers wrote off more in unpaid

fees than they collected in cash payments through the charging system (ibid). The Department of Health and Social Care has struggled to estimate the net gain of the Cost Recovery Programme for the NHS (NAO 2016).

A study conducted by (Weller et al., 2020) sheds light on the impacts of the cost recovery program on Asylum seekers in need of secondary healthcare under the NHS. The study highlighted that Asylum seekers were the group most frequently denied care. Consequently, humanitarian healthcare provision has seen a significant increase in patients since the implementation of hostile environment policies. Additionally, seven percent of those presenting at DOTW clinics (a clinic operated by Doctors of the World) hadn't tried to access NHS care due to fear of being charged or alternatively being arrest, a concern three times more likely among those with undocumented immigration status.

The Médecins du Monde Observatory Report, which included 43,286 individuals, found that over half of those reporting 'fear of arrest' as a barrier to seeking healthcare were in the UK. More recently, health and legal professionals assisting at Grenfell Tower found victims reluctant to go to hospital because of concerns about their immigration status.

Clinicians Responsibilities

Whilst the 2015 and 2017 reforms to NHS charging regulations introduced new administrative procedures, they also brought about a lot of ethically charged questions in the clinical landscape. The conservatives faced backlash by clinicians who opposed the regulations as they felt it embedded immigration enforcement into the everyday routines of hospital care, as it required clinicians to operate within a system that demands both medical judgment and bureaucratic compliance (Medact, 2019).

Under the 2017 amendments, NHS Trusts were instructed to implement charging systems across all departments, including inpatient wards, outpatient clinics and emergency services (Department of Health and Social Care, 2017). Senior managers were made responsible for ensuring compliance, and each Trust was expected to appoint an Overseas Visitors Manager (OVM) to oversee the process. All staff, including clinicians, were expected to understand their obligations under the charging framework. Yet, as Thomas (2017) notes, many Trusts failed to appoint sufficient OVMs, leaving frontline workers to absorb the administrative burden without adequate support.

Evaluations of the Cost Recovery Programme reveal a fragmented picture. Ipsos MORI (2017) found that while awareness of charging policies had increased, engagement at senior

levels remained limited. One in five Trust board members were unaware that some patients could be charged for NHS care. Although some staff supported the principle of charging, the report highlighted growing resistance among frontline clinicians, with support declining over time across several professional groups. This ambivalence reflects a deeper discomfort with the ethical implications of the policy.

The reforms have also blurred the boundaries between clinical and administrative roles. Emergency department staff are now expected to ask patients screening questions to determine their eligibility for free care at the point of registration (Department of Health and Social Care, 2017). Finance teams are required to implement charges rapidly and record a patient's status using their NHS number, which acts as a "consistent identifier" linking care records to residency status and charging eligibility. This systematised tracking of patient status has raised serious concerns about confidentiality and data protection. Briscoe et. al (2025) argue that such practices undermine long standing principles of medical confidentiality, which are protected by both professional codes and legal frameworks. These concerns were amplified by reports that NHS Trusts had shared patient data with credit reference agency Experian to determine whether individuals had a "credit footprint" in the UK, thereby inferring residency status (Gulland, 2019).

Most significantly, the regulations place clinical staff, particularly doctors, in the position of determining whether a patient's condition qualifies as "immediately necessary" or "urgent," and therefore exempt from charging. This decision carries a fiscal dimension that fundamentally alters the nature of the therapeutic relationship. Doctors are trained to uphold the principles of beneficence and non-maleficence, prioritising patient welfare and avoiding harm (Beauchamp and Childress, 2019). Yet under the charging regime, they are asked to make decisions that may result in the denial of care based on a patient's immigration status or ability to pay. Reynolds and Mitchell (2019) argue that this shift risks turning clinicians into gatekeepers of state policy, undermining the founding ethos of the NHS as a service free at the point of delivery. While doctors retain the authority to override administrative decisions and authorise treatment, doing so may be fraught with institutional resistance. Even when treatment is provided, patients may still be billed retrospectively, placing clinicians in ethically ambiguous territory.

The immediacy of these decisions also distinguishes them from other forms of clinical rationing. Typically, decisions about funding are made through formal channels such as

Clinical Commissioning Groups or NHS England's Individual Funding Request process (NHS England, 2017). In contrast, decisions about charging overseas visitors are made in real time, often without oversight, and carry direct consequences for patient access to care. This has raised further concerns about clinical risk, as noted by The Academy of Medical Royal Colleges (2019). If a doctor misjudges the urgency of a condition and care is withheld, the patient may deteriorate, potentially requiring more intensive treatment later or even facing life threatening consequences. The cost of delayed care, both human and financial, can far exceed the original treatment that was denied.

Finally, administrative burden has led to increased workloads and reduced quality of care, completing assessments, verifying documentation and liaising with finance teams are tasks that fall outside the traditional scope of clinical work. Yet under the current system, they have become routine. Thirty five percent of NHS staff reported a rise in workload since the introduction of charging policies, and 70 percent observed a negative impact on service provision (British Medical Association, 2019). Misinformation and inconsistency prevent patients from accessing timely support and hinder clinicians' ability to deliver effective care.

Ethical and Bureaucratic Tensions

Healthcare professionals in the UK are bound by ethical standards outlined by the General Medical Council (2013), which emphasise the importance of prioritising patient welfare and avoiding discrimination. These principles are also reflected in international frameworks such as the Universal Declaration of Human Rights (Article 2) and the United Nations Sustainable Development Goals (Goal 3.8), which advocate for universal access to healthcare. However, hostile environment policies have created conditions where clinicians are expected to enforce immigration restrictions, even when doing so contradicts their ethical obligations. This tension is exemplified in the case of Albert Thompson, a Windrush migrant who was legally resident in the UK for 45 years. Despite being entitled to NHS treatment, he was reclassified as undocumented due to the destruction of landing cards by the Home Office and subsequently billed £54,000 for cancer care he could not afford (Gentleman, 2019). Healthcare staff were forced to deny treatment, despite recognising the potentially fatal consequences, highlighting the ethical strain placed on frontline workers.

This dilemma is echoed in Furman et al.'s (2007) study, which asked social care students how they would respond to vulnerable individuals morally entitled to support but legally excluded

due to immigration policy. The majority prioritised human need over legal compliance, with some admitting they would risk penalties to ensure access to care. Others, however, expressed concern about the consequences of defying policy, citing fears of job loss or institutional closure. These findings suggest the moral dissonance experienced by frontline workers, who must navigate between professional ethics and legal obligations.

Dourgnon et al., (2023) brings into question the development of the polices, implying, had participatory approaches such as Post Normal Science (PNS) been employed in the development of hostile environment policies, the lived experiences of healthcare providers could have informed the process. They suggest this would have allowed for the identification of ethical tensions and the creation of policies that better support both patients and clinicians.

Beyond ethical concerns, NHS charging policies present significant practical challenges. The guidance surrounding these policies now spans over 130 pages (Mahase, 2021), and many healthcare professionals lack a clear understanding of when and how charges should be applied. This complexity leads to inconsistent practices across NHS Trusts and increases the risk of errors. In some cases, confusion around charging criteria has enabled prejudicial decision making, allowing personal biases to influence access to care (Shahvisi,et al.2019).

Studies have shown that healthcare providers frequently misidentify who is exempt from charges, particularly among migrant groups (Floyd and Sakellsriou, 2017; Hiam et al., 2017; Rassa et al., 2023). This knowledge gap undermines the legitimacy of the NHS and compromises its ability to deliver equitable care. According to the General Medical Council (2013), practitioners must be competent in all aspects of their role, including legal and regulatory frameworks. Yet the British Medical Association (2019) found that nearly one in five NHS workers were unaware that patients could be charged for care, and among those who were aware, many misunderstood the rules. For example, 76 percent of respondents incorrectly believed that all immediately necessary care was exempt from charging (Jones et al., 2019). Similarly, 40 percent of participants in Ipsos MORI's (2017) study believed that all care was chargeable for non-exempt persons.

There is also widespread confusion about who qualifies for exemptions. Many clinicians struggle to distinguish between refugees, asylum seekers and undocumented migrants, despite their differing entitlements. This lack of clarity can result in eligible patients being denied care. Less than half of British Medical Association members reported confidence in their knowledge of charging regulations, and 72 percent identified a need for further training

(Jones et al., 2019; Feldman et al., 2019). The absence of formal instruction, aside from optional online modules, places additional strain on NHS staff, who must interpret complex policies without adequate support.

Literature review

As hostile environment policies continue to tighten and tensions surrounding migration in the UK intensify, the questions posed by this thesis become increasingly necessary and timely. Healthcare professionals are now more involved than ever in immigration enforcement, often in ways that conflict with their clinical responsibilities and ethical obligations. While existing literature has extensively documented the impact of these policies on migrants their access to care, their experiences of discrimination, and the broader public health consequences, there remains a significant gap in understanding how these same policies affect those tasked with implementing them and how they are navigated.

After extensive reading around the topic, it is clear that the most common trend in the literature is a focus on migrant experiences. Migrants are, understandably, the primary targets of hostile environment policies and the most visibly affected. However, what often goes unnoticed is the impact on healthcare professionals, who are expected to enforce these measures regardless of their moral stance or clinical judgement. Although some studies have helped clarify how these policies are operationalised within the NHS, they rarely centre the voices of healthcare professionals or explore the ethical tensions they face. This thesis addresses that gap by placing healthcare professionals at the centre of analysis and examining the moral and professional dilemmas they encounter. By focusing on doctors as frontline actors, the study contributes to a deeper understanding of how policy is enacted in practice and how discretion, moral judgement and institutional constraints shape clinical decision making.

Much of the existing work continues to focus on migrant experiences. Essex et al. (2022), for example, provide a strong critique of the hostile environment's impact on migrant health, outlining how charging regulations, data sharing practices, and fear of deportation deter individuals from accessing care. Their analysis includes cases such as Simba, a refused asylum seeker who suffered a stroke after avoiding treatment due to concerns about upfront charging and immigration enforcement. Although the focus is not on healthcare professionals, the consequences of policy implementation on patients indirectly expose the ethical and professional tensions experienced by NHS staff. In this way, literature that centres migrant

experiences still contributes to understanding the moral dilemmas and discretionary practices of healthcare workers, which are explored more directly in this thesis.

Zhang et,al. (2023) also focuses primarily on the impacts the policies have had on migrants, specifically in relation to the NHS Digital Home Office data sharing agreement. The study explores how fear of deportation and mistrust in the NHS deter migrants from accessing care. However, it also offers valuable insight into the ethical and professional tensions experienced by healthcare workers, which are central to this research. The study found that many healthcare professionals were unaware of the specifics of the data sharing agreement or were confused about its scope, reflecting a wider lack of transparency in how these policies are communicated. This uncertainty created a climate of fear and suspicion, not only among patients but also among clinicians, who felt that their professional obligations, particularly around confidentiality and informed consent, were being undermined. Some participants described using informal workarounds, such as withholding patient contact details from records, to protect vulnerable individuals. These responses reflect the concept of street-level discretion, where frontline workers adapt or resist policy implementation to uphold ethical standards.

The study also highlights how the blurring of boundaries between healthcare and immigration enforcement can compromise patient safety. One participant described a case where a pregnant woman used her sister’s identity to avoid detection, which led to a near fatal transfusion error. Such examples demonstrate the public health risks of policies that deter migrants from seeking timely care. Although the study does not explicitly frame its findings through a theoretical lens, its exploration of power dynamics, ethical conflict, and professional resistance aligns closely with the themes of this thesis. It shows how healthcare professionals are caught between institutional mandates and their duty of care, a tension that is examined more systematically in this research through the lens of street level bureaucracy.

Other studies, although not directly concerned with healthcare professionals, have offered important insights into the pressures they face under hostile environment policies. These insights are often embedded within broader discussions on migrant access to care and require close reading to uncover their relevance. One such example is the work by Pierce and Adil (2025), conducted a study into the effects of hostile environment policies on maternity care for refugees, asylum seekers, and undocumented migrants in Camden. Whilst the study's focus was on the patients, they noted in their conclusion that the policies had “undermined

their (healthcare workers) duty of care, personal morals, and the principles of the NHS" (Pierce & Adil: 1 2025). And whilst their findings have been of great value and of great inspiration to this thesis, the undermining of the duty of care is not the central analytical concern of the paper.

Instead, Pierce & Adil frame a small section of their paper to these ethical tensions as part of a broader landscape of systemic barriers to care, highlighting how healthcare professionals and community organisations adapt their roles to mitigate harm. Their thematic analysis captures the emotional and professional strain experienced by staff, for example midwives facing confusion over charging regulations, fear of breaching confidentiality, and the moral discomfort of enforcing immigration controls. But these are presented as part of the service delivery context rather than explored through a theoretical lens. The paper does not delve into the discretionary practices or moral reasoning of healthcare professionals in depth, nor does it engage with a theoretical framework.

Although it was a small section of their paper, this thesis aims to build on Pierce & Adil's groundwork by placing healthcare professionals at the centre of the analysis. It aims to critically examine how doctors interpret, negotiate, and sometimes resist hostile environment policies in their everyday practice. By doing so, I hope this thesis can contribute to a deeper understanding of how ethical tensions are lived and managed on the care setting, and how policy is enacted not just through legislation, but through the discretionary actions of those tasked with its implementation.

Wharton Smith & Campos, et al's (2019) study is cited as the first academic exploratory study of the experiences and perspectives of healthcare professionals as opposed migrant patients in relation to the patient data sharing agreement between National Health Service Digital and the Home Office. Their design was a qualitative study using semi-structured interviews, thematic analysis and constant comparison approach, their participants included eleven healthcare providers and one non clinical volunteer working in community or hospital based settings who had experience of migrants accessing NHS England services. Interviews were carried out in 2018. Whilst I have drawn inspiration from their study, the paper has ultimately become outdated, due to changes in data-sharing regulations within NHS digital. In addition, the paper much like a lot of the literature in this field is an empirical report, which has been of value to the thesis as a means of relying on research that carries a sense of objectivity. However, there is no theoretical exploration of the findings, and as a result, the

discussion is limited in its ability to capture the richness and nuances present in this social context. What remains notably absent is a deeper engagement with the broader socio-political dynamics that underpin these experiences such as power relations, institutional accountability, and the moral dilemmas of data sharing practices. Without this kind of framing, the complexity of the issues at hand risks being flattened or oversimplified. I am aware that this is a gap in the literature, which I hope to address in my own thesis by offering a more critically informed and conceptually grounded analysis.

Whilst it is important to note this is not a criticism of Wharton Smith & Campos's paper, nor a dismissal of its empirical contributions, as it does not make their paper any less credible given their intention was to present an empirical report. However, I am highlighting that there is a noticeable absence of critical engagement with the findings of such studies. In response to this gap, I have chosen to employ Michael Lipsky's theory of street level bureaucracy as my theoretical framework. Utilising this lens has allowed this thesis to have a deeper exploration of how doctors, as frontline actors, navigate the ethical and procedural tensions introduced by hostile environment policies. It allows this thesis to critically examine how discretion, moral judgement, and institutional constraints shape the implementation of immigration control within healthcare settings, often in ways that conflict with the principles of the NHS and the professional duties of care. I will return to this theoretical framework later in the thesis to explore its relevance to the research findings in more depth.

There are articles and reports that have been written by organisations and collectives such as Doctors of the World, Docs not Cops and patients not passports for the purpose of their campaign, which has been detrimental to shedding light on the widespread opposition to these policies within the healthcare community, ultimately, they are a form of activism and therefore frame their findings through advocacy rather than detached analysis. Without reports such as 'An audit of Doctors of the World's Hospital Access Project' produced by Doctors of the World (2020). I may not have even considered the effects hostile environment policies have on healthcare professionals, through reading such reports I have gained an understanding of the obligations healthcare professionals had post the implementation of hostile environment policies, I could sympathise with their cause and I actually had an awareness there is opposition within the healthcare community, so I owe homage to such groups for inspiring my thesis. However, due to the limited academic literature that engages directly with healthcare professionals, my thesis has necessarily drawn on activist sources. While these are invaluable in highlighting lived experiences and ethical concerns, they are

often shaped by advocacy goals, which means they may not always provide the methodological transparency or theoretical grounding expected in academic research. which makes it harder to place their insights within wider academic conversations or to unpack the deeper structural issues behind the policies they critique.

For example, the *Patients Not Passports* report, titled *Learning from the International Struggle for Universal Healthcare* (Button et al., 2020), published by the New Economics Foundation, a British think tank promoting "social, economic and environmental justice," offers a detailed account of the impact of NHS charging policies and data sharing practices. Drawing on case studies, international comparisons, and personal testimonies, the report highlights how these policies have negatively affected migrant communities and placed healthcare professionals in ethically complex situations. Despite its value in illustrating these issues, the report lacks methodological transparency. It does not specify how data was collected, how sources were selected, or how findings were analysed. This absence makes it difficult to assess the reliability and representativeness of the evidence presented. Additionally, the blending of anecdotal narratives with policy critique has blurred the line between advocacy and empirical analysis.

In contrast, academic studies such as Dobbin et al. (2022) and Pierce and Adil (2025) provide clearly defined research designs, sampling strategies, and analytical frameworks, allowing for critical scrutiny and replication. These studies also engage with established theoretical debates, contributing to a deeper understanding of the structural and institutional dynamics at play. While activist literature such as *Patients Not Passports* is valuable for raising awareness and documenting lived experience, it must be complemented by scholarly research that offers conceptual clarity and methodological rigour. This study has a qualitative approach using semi structured interviews to examine how doctors understand and respond to hostile environment policies in clinical practice. The majority of participants were selected from outside activist networks such as Docs Not Cops or Patients Not Passports in order to capture perspectives shaped by routine clinical experience rather than organised resistance. By doing so, this thesis aims to produce a more grounded and analytically robust account of how healthcare professionals navigate the ethical and procedural tensions introduced by these policies. The methodology is discussed in further detail further on.

Theoretical Framework

Michael Lipsky's concept of street-level bureaucracy offers a useful framework for understanding how doctors interact with hostile environment policies within the NHS. Developed through research with frontline service providers in the United States including teachers, police officers and social workers, Lipsky (1980/2010) conceptualised street-level bureaucracies as institutions where public service workers exercise significant discretion in the allocation of services and enforcement of regulations. These are the spaces where individuals directly encounter the state and experience the practical realities of policy implementation (Lipsky, 2010, p. xi).

In bureaucratic systems such as healthcare, education and employment, frontline workers are tasked with interpreting broad policy directives and applying them to specific cases. Through these everyday decisions, they mediate the relationship between policy and people's lives. Lipsky argued that the routines, judgements and practices of street level bureaucrats effectively constitute the policies they are charged with implementing (Lipsky, 2010, p. xiii). In this way, service provision becomes a site where governance is enacted and experienced.

Within the NHS, doctors operate as street-level bureaucrats. Their decisions such as whether to charge a patient, share data with immigration authorities or assess eligibility for care, are shaped by institutional guidelines but also by their own professional values and ethical commitments. These interactions reveal the tensions between policy ideals and the realities of clinical practice, particularly in the context of hostile environment policies that seek to restrict access to healthcare for certain migrant groups.

Lipsky's work draws attention to the contradictions faced by street level bureaucrats. They are expected to deliver equitable and compassionate care while simultaneously adhering to policies that may undermine these principles. Often working under conditions of limited time, high caseloads and resource constraints, they develop coping mechanisms that ration their attention, energy and organisational resources in ways that reflect their capacity to manage stress (Moore, 1987, p. 76). These adaptations can reinforce system defined norms and expectations, many of which are linked to broader mechanisms of governance and control.

In healthcare settings, such dynamics are evident in the ways that discourses around personal responsibility and entitlement shape normative expectations for patients. Healthcare professionals may be required to assess immigration status or determine whether a patient should be charged for care, thereby participating in a system that prioritises administrative

efficiency over holistic, patient centred care (Lipsky, 2010, p. 71). These practices illustrate how street level bureaucrats can become agents of social control, even when such roles conflict with their professional obligations.

As seen in the confusion surrounding the cost recovery program, the directives that these workers receive are often vague, ambiguous and conflicting, and lend themselves to multiple interpretations. As a result, healthcare professionals find themselves in situations where they must exert not only technical discretion but also morally laden judgement. The proper functioning of bureaucratic systems depends, to some extent, on the capacity of these workers to act as sound moral agents (Zacka, 2017). Yet the conditions in which they operate are extremely demanding. The routine of everyday work consists of emotionally draining encounters with vulnerable patients, and they must contend with limited resources due to chronic understaffing. They are constantly forced to make difficult compromises between competing values that are central to democratic political culture efficiency, fairness, responsiveness and respect (Zacka, 2017). The need to navigate these tensions on a daily basis often leads to psychologically exhausting decision making.

What this research reveals is that street level bureaucrats respond through a range of coping mechanisms, one of which is moral specialisation. Since they cannot fulfil every aspect of their role equally, they tend to focus on one dimension, such as compassion, compliance or efficiency, and develop reductive dispositions that simplify their ethical landscape. This leaves us in a troubling position. On the one hand, the proper functioning of bureaucracies depends on the ability of frontline workers to exercise balanced moral judgement. On the other, the very conditions of their work erode and undermine that capacity.

However, street level bureaucrats also possess the ability to resist or reinterpret policies they perceive as misaligned with their values. When prevailing structures appear to compromise principles such as client centredness or equity, practitioners may make situational judgements that deviate from formal policy, informed by dialogue with patients and local professional cultures (Ewalt and Jennings 2004). These discretionary decisions reflect the complex interplay between policy, context and professional ethics.

Discretion, the ability to decide what should be done in a particular situation, is a fundamental aspect of street level bureaucratic work (Barnes and Henly, 2018). As Maynard Moody and Musheno (2012, p. S19) note, street level bureaucrats operate in spaces where abstract rules confront specific circumstances and individuals. Their judgements are shaped

by the need to reconcile general policy with the particularities of each case. While such decisions often reproduce existing systems (Maynard Moody and Musheno, 2012), they can also serve as avenues for resistance and transformation, especially when practitioners act in ways that prioritise patient welfare over bureaucratic mandates (Tummers and Bekkers, 2014).

This understanding of street level bureaucracy highlights two key ideas relevant to this thesis. First, the everyday practices of doctors can be seen as responses to the broader systems within which they work. Second, their discretionary decisions have the potential to either reinforce or challenge the policies and structures that shape healthcare provision. By examining how junior doctors navigate hostile environment policies through interviews and observations of advocacy spaces such as Patients Not Passports, this thesis explores how policy is enacted, contested and reshaped at the frontline of the NHS.

Methodology

Epistemology

This thesis is situated within a critical realist epistemology whilst integrating interpretivist elements. This provides the conceptual foundation for exploring how doctors interpret, negotiate and respond to hostile environment policies within the NHS. Critical realism combines a realist ontology with a relativist epistemology (Ackroyd and Fleetwood 2003). It recognises that while structures such as immigration legislation, NHS protocols and institutional hierarchies exist independently of individual perception, our understanding of them is always shaped by lived experience and social context (Bhaskar 2009).

Following Al Amoudi and Willmott (2011), this thesis acknowledges that social reality is not external to human activity but is constituted through it. The transitive dimension how individuals interpret and engage with policy is nested within the intransitive structures that shape their environment. In this context, doctors are not passive executors of state mandates. Their decisions whether to charge a patient, share data with immigration authorities, or advocate for vulnerable individuals are shaped by institutional constraints, ethical obligations, and personal values. These discretionary practices reflect the tensions between policy ideals and clinical realities and are best understood through the lens of street-level bureaucracy (Lipsky, 2010). This framework is developed in greater detail in the theoretical chapter, where I argue for its relevance in capturing the discretionary agency of frontline clinicians.

Street-level bureaucracy is a recognised mechanism for policy evaluation, particularly in contexts where implementation is not directly controlled and can diverge significantly from intent (Smith et al., 2012; Goldfinch and Wallis, 2010). It allows for an examination of situated agency how actors make sense and meaning in relation to context (Durose, 2009) and supports the epistemological relativism central to this study. I have included an interpretive dimension here, as the research is concerned not only with what doctors do, but also how they make sense of their actions, how they experience ethical tension, and how they construct meaning in the face of conflicting obligations. This interpretivist lens enables a deeper engagement with the subjective dimensions of discretion and professional identity.

The integration of interpretivist elements was a result of the research aims. Interpretivism which is particularly well suited for exploring how individuals make sense of complex and evolving policy environments. Rather than seeking a single, objective truth, interpretivism recognises that clinicians' behaviours and decisions are shaped by their personal perceptions, the institutional settings they work within, and their ongoing interactions with both colleagues and patients. These interactions are central to how clinicians experience hostile environment policies in practice (Pascale, 2010; Creswell and Poth, 2016; Denzin and Lincoln, 2011). The aim here is not to produce sweeping conclusions or universal claims about how all NHS staff respond, but to offer a grounded account of how a particular group of doctors make sense of and manage the conflicting demands they face. This approach is rooted in an interpretivist commitment to understanding lived experience and meaning making within specific institutional and social contexts (Mason, 2018). It recognises that clinical decisions are shaped by policy, yes, but also by interpersonal dynamics, ethical tensions, and the discretionary space clinicians occupy. These dimensions are directly reflected in my research questions, which seek to understand how clinicians interpret and respond to policy pressures, and how their values and institutional constraints shape those responses. As a result, what emerges from these interviews illuminates clinicians' negotiation of the policy and how it is felt, often through the use of discretion.

Thus, by combining critical realism with interpretivism, this thesis is able to trace how macro-level policy decisions produce micro-level ethical dilemmas, and how these are navigated through discretionary practices. The combination of realism and interpretivism also allows this thesis to examine how institutional ambiguity and the complexity of hostile environment policies have created space for either compliance or resistance. Interpretive realism, as developed by scholars such as Al Amoudi and Willmott (2011) and Sayer (2000),

provides a framework for recognising that social structures are real and constraining, yet always mediated through human interpretation and agency.

Sampling

A purposive sampling strategy was employed to identify participants who could provide the most relevant and insightful perspectives on the research questions. Purposive sampling is particularly appropriate in qualitative research where the aim is to gain depth and richness of understanding from individuals with direct experience of the phenomenon under study (Palinkas et al., 2015; Ritchie et al., 2013). Doctors were selected as the primary group of interest due to their frontline role in the implementation of NHS policies and their unique position at the intersection of clinical care and immigration enforcement. Their responsibilities around patient eligibility, data sharing, and fee charging place them in direct contact with the operational dimensions of hostile environment policies.

Within this group, I deliberately focused on doctors those in the early years of their careers, prior to specialisation. This decision was informed by several considerations. First, early career doctors rotate through a wide range of departments, exposing them to diverse clinical contexts and policy encounters. Their accounts therefore offer a broader cross section of NHS practice. Second, early career clinicians are still in the process of forming their professional identities and may be more reflective about institutional norms and tensions (Monrouxe and Rees, 2017). Rather than assuming openness, this choice is grounded in literature suggesting that professional identity formation is particularly dynamic during early training stages, making these doctors more likely to articulate ethical dilemmas and institutional contradictions (Cruess et al., 2015).

The geographical focus on South Wales was both deliberate and theoretically informed. South Wales holds historical significance as the birthplace of the NHS, with enduring Bevanite principles of universalism and equity. The region's distinctive political context, characterised by devolved health policy under a Labour led Welsh Government, contrasts with the hostile environment agenda introduced by the UK Conservative Government. In the UK, healthcare is a devolved in Wales. However, immigration policy remains reserved to the UK Government, and hostile environment measures, including data sharing with the Home Office and upfront charging for certain categories of migrants, continue to apply across all four nations (UK Government, 2017; Medact, 2019). While the Welsh Government has publicly opposed these measures and emphasised its commitment to universal access to care, it does

not have the legislative power to opt out of the charging regulations entirely (Welsh Government, 2019; Senedd Cymru, 2022). This creates a complex and often contradictory policy environment in which NHS Wales is required to implement aspects of a national immigration agenda that conflict with its own stated commitments to equity and inclusion. This tension makes South Wales a particularly valuable site for exploring how frontline clinicians interpret, negotiate, and at times resist the implementation of hostile environment policies within a devolved healthcare system.

Cardiff, in particular, was chosen for its ethnic diversity, the presence of a significant refugee and asylum seeker population, and the existence of a clinic specifically dedicated to undocumented migrants. As of 2024, Cardiff alone hosted over 1,100 asylum seekers receiving government support more than any other local authority in Wales (Home Office, 2024). In addition, South Wales is estimated to host between 12,000 and 15,000 undocumented migrants, many of whom fall into categories subject to NHS charging under UK Government regulations (Rodríguez Sánchez and Tjaden, 2025).

Participants were recruited through a combination of direct outreach and snowball sampling. These methods are well suited to research involving politically sensitive topics and hard to reach populations (Noy, 2008; Atkinson and Flint, 2001). Initial contacts were made via professional networks, NHS Trusts, and advocacy organisations. Subsequent participants were identified through referrals from interviewees, leveraging existing professional and social connections to access a broader and more diverse sample. This approach was particularly effective in reaching clinicians who may have been hesitant to participate in research on such a politically charged issue.

A good example of how this played out in practice: one of my interviewees mentioned that a colleague of theirs was involved in the Welsh branch of Patients Not Passports. With their permission, I was put in touch, and this connection ended up being my route into the PNP meetings and group chats. Without this kind of personal referral, it’s unlikely I would have been able to gain the level of access I did, particularly to activist spaces that are understandably cautious about outsiders. This approach not only helped me reach clinicians who might otherwise have been reluctant to take part but also opened doors to observe the dynamics and discussions within advocacy groups that are usually closed to researchers.

Data Collection

Semi-structured Interviews

The core of my data collection was semi-structured interviews with doctors based in South Wales. I landed on this method after testing and trialling Q methodology. A noticeable problem with Q methodology was its limited capacity to explore case examples, something essential to the thesis's ambition to analyse and pick apart how and why discretion is used. While Q might have been a useful tool for examining attitudes towards the policies particularly because of the absence of interviewer bias it would have completely restricted me from accessing personal stories or anecdotes, which have become central to my analysis. These could only really be obtained through either unstructured or semi-structured interviews. Not to mention, semi-structured interviews allowed me to get at the actual reasons discretion was used, as the method allowed to ask outright.

Given my primary research question: How do NHS doctors navigate hostile environment policies in their everyday clinical practice? I developed an interview guide to ensure that key topics such as attitudes to fee charging, data sharing, professional obligations, and ethical dilemmas were consistently addressed. The decision to use a structured interview guide was driven by a desire for consistency across interviews and, candidly, by a lack of confidence in my own abilities as an interviewer. I was uncertain whether I would be able to stay on topic without a framework, or whether I could generate data of sufficient depth and relevance without one. In retrospect, I remain ambivalent about whether unstructured interviews might have been more appropriate. I relied on the guide particularly during moments when the conversation felt stagnant, which at times resulted in abrupt shifts that disrupted the natural flow of dialogue. In interviews constrained by time, the guide functioned more as a checklist to ensure coverage of key themes, rather than as a flexible tool to support open, organic discussion. This ongoing tension between structure and spontaneity continues to shape my reflections on the research process.

Ultimately this is an extremely personal and politically charged topic, although the interviews followed a loose structure, I feel confident that I left sufficient space for participants to raise the issues that mattered most to them, and to share personal stories or cases

After reading around research methods, my methodological choices were also influenced by the academic literature for which largely states Semi structured interviews are particularly well suited to healthcare research (Gill et al., 2008; Kallio et al., 2016). Gill (2008) implies

that semi-structured interviews are necessary for remaining respectful to participants when exploring sensitive topics, such as moral discomfort and professional resistance, as the structural aspect of the interview helps participants feel that the conversation has a clear purpose and will stay within the boundaries they've agreed to.

Interviews typically lasted between one and two hours, and were conducted either in person or via video call, depending on what was most practical for the participant. The first three interviews were exploratory, at that stage, my theoretical framework and main research questions were still evolving, reflecting an abductive approach. These early conversations were invaluable for shaping the direction of the project and surfacing themes I had not anticipated. As the research progressed and my analytical focus became clearer, the final two interviews were more directly informed by emerging theoretical concerns. Nevertheless, I made a conscious effort to keep the interviews as consistent as possible, so that the data would be comparable while still allowing for new insights to emerge organically. On reflection, abduction was particularly well suited to the research as the ambition was to understand a complex, context dependent phenomenon, (Timmermans and Tavory, 2012; Tavory and Timmermans, 2014). The approach meant I could refine conceptual frameworks in response to empirical findings, instead of imposing a fixed theoretical lens from the outset (Charmaz, 2014; Blaikie, 2007). Thus, allowing the study to remain responsive to what participants were actually saying, while gradually sharpening the analytical lens I used to make sense of their accounts

One of the main challenges I encountered was the expectation rooted in both professional codes and NHS culture that clinicians should remain "apolitical." Given how politicised migration policy is in the UK, in the past decade "Migration is no longer treated as a technical issue of governance, it has become a symbolic battleground where parties stake out moral authority and national identity" (Cashman, 2025). The expectation that clinicians should remain apolitical likely influenced what participants felt comfortable sharing, especially when it came to expressing moral discomfort or disagreement with the policies. I recognise this as a limitation, and it is something I have reflected on throughout my analysis.

The interview guide covered a range of topics: clinicians' understanding of hostile environment policies, their experiences with fee charging and data sharing, the ethical and professional tensions they had encountered, and their perceptions of how these policies affect patient care. I also invited participants to share specific case examples, reflect on their

training (or lack thereof) for treating migrants, and discuss any strategies they used to navigate cultural and language barriers. Importantly, I treated the guide as a framework rather than a script if participants raised issues I had not anticipated, I followed their lead.

Participant Observations

In addition to interviews, I conducted participant observation within Patients Not Passports (PNP) meetings and their associated online spaces. Participant observation, as described by Kawulich (2005), involves immersing oneself in the natural setting of the group under study to gain a deeper understanding of group dynamics, practices, and communication patterns. My role was primarily that of an observer as participant: group members were aware of my research objectives, but my main focus was on observation rather than active participation. This approach was chosen for its ethical transparency and to minimise disruption to the group's activities (Gold, 1958).

While it would have been valuable to interview PNP members to better understand their motivations for activism, I decided against this to avoid introducing bias. My research focus was on ordinary clinicians, not activists whose experiences and perspectives might be atypical. During my observations, I became aware of a certain wariness among group members, likely reflecting the highly polarised political climate around migration in the UK. My presence may have influenced the natural dynamics of the meetings a phenomenon similar to the Hawthorne effect and this is a limitation I acknowledge.

Clinicians are bound by strict confidentiality obligations, and the discussion of patient cases within activist meetings posed ethical dilemmas. I was repeatedly asked to censor my notes to protect patient privacy, and I complied fully with these requests. Despite these constraints, my extended engagement with the group including several months of access to online discussions, project materials, and formal correspondence with NHS Wales provided valuable insights into the focus and strategies of healthcare activism, which I draw on in my analysis.

Ethical Considerations

Ethical integrity was central to every stage of data collection. Informed consent was obtained from all interview participants, who were made aware of the research aims, their right to withdraw, and the intended use of their data. Confidentiality was rigorously maintained, with all identifying information anonymised in transcripts and field notes. In line with the General Medical Council's (2013) guidance on confidentiality, particular care was taken to avoid the

disclosure of sensitive patient information during both interviews and observations. The research was conducted in accordance with institutional ethical guidelines and the principle of “do no harm” (Tracy, 2010; Silverman, 2017).

All participants received detailed information sheets outlining the aims, scope, and ethical considerations of the study. Informed consent was obtained prior to participation, with assurances of confidentiality, anonymity, and the right to withdraw at any stage.

Limitations and Reflections

There are several limitations to this approach. The expectation of political neutrality among clinicians may have constrained the openness of interview responses, particularly regarding moral discomfort or dissent, this is further discussed in the findings. In relation to the expectation that clinicians should be politically neutral, my presence in Patients not Passports meetings may have influenced group dynamics and the authenticity of observed interactions, possibly making participants feel wary of my presence.

In addition, the reliance on snowball sampling may also have introduced selection bias, potentially limiting the diversity of perspectives captured. During the coding process, I noticed a lack of polarisation in attitudes towards the policies I fear this may have been a direct response to the reliance on snowball sampling, as many of the doctors interviewed worked in similar clinical environments and shared overlapping professional networks.

In addition, given the emotional and personal weight of the topics discussed, it would have been more appropriate to provide interview questions in advance. This would have allowed interviewees time to reflect and consider how they wished to articulate their responses, this could have allowed for a richer and more thoughtful data set by reducing the pressure to respond spontaneously.

Despite these limitations, combining semi-structured interviews with participant observation provided a rich dataset. This approach enabled me to explore not just what doctors do, but how they make sense of the ethical and procedural tensions created by hostile environment policies. Maintaining a reflexive stance throughout the research process has, I hope, enhanced the credibility and trustworthiness of my findings.

Coding

Originally, when coding the data, I took the approach of thematic analysis. This was mainly for practical reasons, I wanted the data to be organised in a way that allowed me to identify recurring ideas quickly. I had created a graph that revealed overlapping themes, and I used this to guide my reading of each interview. I found myself adopting Braun and Clarke's (2006) reflexive model, a habit carried over from previous projects, which led me to highlight patterns in the interviewees' language and experiences.

However, this quickly became a problem. Thematic analysis, particularly in its reflexive form, focuses on the surface level of what is said, rather than interrogating why it is said or how it relates to deeper structural mechanisms. I had to reconsider the ambition of my research, which is to explore how junior doctors navigate ethical and procedural tensions introduced by hostile environment policies. It became clear that simply categorising surface level themes across interviews would not allow me to interpret the data in a way that aligned with either my research aims or my epistemological position. My research is not only concerned with what doctors say, but with how their stories reflect ethical and professional tensions, how they use discretion, and how they engage in resistance or compliance with policy. These are not just themes they are expressions of how individuals make sense of their roles within a system that often contradicts their professional values. Thematic analysis, in this context, risks reducing these complex experiences to simplified categories.

From a critical realist perspective, this presents a clear limitation. Critical realism suggests an analytical approach that distinguishes between the empirical, the actual, and the real (Bhaskar, 2008). Thematic analysis often remains at the empirical level, what is observed or reported without necessarily engaging with the causal mechanisms or structural conditions that shape those experiences. These risks flattening the complexity of the data and obscuring the institutional tensions that are central to this thesis.

From an interpretivist perspective, thematic analysis also falls short in capturing the nuanced meaning making processes of participants. My interviews reveal not just attitudes, but moral discomfort, emotional labour, and situational judgement. These are not easily reduced to thematic categories. They require a more reflexive approach, one that attends to how meaning is constructed in relation to institutional power, professional identity, and ethical responsibility.

As a result, I recoded the data using a narrative approach inductively. Instead of coding my data by tearing my transcripts into quotes, I broke off my transcripts based on stories and larger narrative blocks, and compared those blocks across interviewees to identify a few core narratives independent of my theoretical lens. This doesn't mean every story fits neatly into one narrative there's nuance, and part of the aim was to embrace and communicate that nuance. The narratives weren't decided beforehand or shaped by theory they came directly from the data, based on how participants told their stories and what they focused on.

An addition, I chose not to treat the transcripts as neutral records. I paid attention to tone, sequencing, and what was emphasised or left out. For instance, a case that is discussed in the analysis Lizzie's shame around the use of discretion was interpreted by the interviewee's pauses and tone as opposed to solely what she said. I wasn't trying to check for accuracy or whether something was objectively correct. In accordance with my research philosophy, I was more interested in how participants shaped their stories how they made sense of their roles, decisions, and the tensions they were working within. This was especially important in my observations, where meaning wasn't always verbal. In meetings and activism spaces, I looked at how people framed their roles and how resistance was communicated through shared language and action.

Findings & Analysis: Part 1

The NHS

For international readers, in order to understand the professional tensions at play it is important to gain an understanding of the significance the NHS holds within British society. Unlike other state institutions such as education or transport, the NHS has developed a cultural momentum which sets it apart. As Christine pointed out during interview, the NHS is "rolled out like a brand" in the UK (Appendix, p.223), and this branding has become a key component in the ethical and professional tensions experienced by healthcare workers. The phrase 'Save Our NHS' has appeared in multiple UK general election campaigns, including Labour's 2019 and 2017 manifestos, where it was used to oppose privatisation and funding cuts (Labour Party 2019; 2017). The use of possessive language such as 'our NHS' is often used to reinforce the communal nature of the institution and the emotional investment the public has in its continued existence (National Archives 1948; Seaton 2015).

A common theme identified in the interview data was the importance placed by doctors on upholding NHS values. Many expressed discomforts with policies such as fee charging, which they felt were incompatible with the founding principles of the NHS. These principles, often referred to as Bevanite values, include equity, universality, and care free at the point of delivery (Timmins 2017). Those same values and principles are integrated into the NHS constitution to date, with the first three principles of the constitution being;

1.The NHS provides a comprehensive service, available to all

2. Access to NHS services is based on clinical need, not an individual's ability to pay

3. The NHS aspires to the highest standards of excellence and professionalism (Department of Health and Social Care, 2023)

Rebecca stated that being asked to charge a patient would make them feel "incredibly uncomfortable," explaining: "I think I mentioned Aneurin Bevan's core values for the NHS and one is equity and medical care being free at the point of care, so I think it completely undermines those values. It would make me feel uncomfortable and it would make me feel sad." (Appendix, p.60) The value Rebecca places on NHS values and Bevan's founding ethos speaks to the professional tension she feels. She's been taught and conditioned throughout her training to work by those principles, associating the morality of care with them, yet she's asked to implement policy that in her assessment directly contradicts them. What I found particularly insightful was how the values and principles of her employer are treated not just as institutional guidelines, but as a kind of moral framework she feels obliged to follow.

The NHS was mentioned 92 times across the interviews, often in connection with values, identity, and moral responsibility. Lizzie, when asked whether they felt passionate about NHS values, responded affirmatively "Yeah." When prompted to elaborate, they explained: "It makes sense that everyone should… like the principle is like health care given on need. I don't think you can get anything like fairer than that." (Appendix, p.170) They went on to reflect on the metaphor of the NHS as a national religion: "I did read somewhere that the NHS is the closest thing that UK has to a national religion, which I think everyone is very invested in… even if it's like falling apart." (Appendix, p.170) This aligns with Klein's (2013) description of the NHS's founding as "an act of social communion," and with Titmuss's argument that institutions like the NHS nurture "sentiments of altruism, reciprocity and social duty … by all social classes" (1970, 292). Although Rapport and Maggs (2002) question the unconditional nature of the altruism Titmuss describes, they acknowledge that

reciprocity within public institutions promotes a “heightened sense of communal sharing” (p. 497). The association of the NHS with religion, despite it being a secular institution, lives into the previous observation made that clinicians like Rebecca are using NHS values as a moral framework, similar to how one would with the teachings and values of their religion. Rebecca feels so aligned and committed to the values that she overrides government policy through discretion (a case that will be discussed further on) clearly exemplifying the professional tension at play.

The professional tension and the reasons behind such tensions were further solidified in Rebecca’s concern that the founding principles were being undermined, stating: “I think it’s sad that those principles are being tampered with… I don’t know whether that’s long standing or whether that’s just like in the current climate.” (Appendix, p.58) She went on to describe how political shifts have impacted the institution: “It’s just such a shame to see that the NHS can be changed based on who’s in power at the time… like fee charging and the data sharing and the whole hostile environment plan was made purely because Theresa May at the time was like super stringent on migrants.” (Appendix, p.58) Whilst her concern of course, reveals clinicians' homage and prioritisation of NHS values over government policy, and thus professional tensions. It also reflects the vulnerability of NHS values to political influence and the difficulty of reversing policies once implemented.

But ultimately, when looked at through discretion as a form of resistance, which will be discussed further into the analysis, it highlights something intriguing that, some clinicians such as Rebecca feel it is necessary to uphold the values of the NHS even if it means breaking government-mandated instructions. This plays into the idea that The NHS’s role as a public institution held in common by all members of society contributes to its symbolic power. The use of inclusive language in early promotional materials, “your NHS”, and Bevan’s appeal to the medical profession, “we can try together to secure the improvements we all want”, reinforced the idea of collective ownership and shared responsibility (Bevan 1948; Seaton 2015) a theme that is clearly evident in the data.

Ethical Tensions

In the context of homage to NHS values, its significance is clear, the reason why this thesis highlights it is that the data shows that interviewees placed great importance and meaning on the principles of the NHS. Which creates a tension as a street level bureaucrat, they are left to operate between two institutional logics: the NHS Constitution, which embodies universalism

and care based on need (DHSC 2015), and government policies that impose exclusionary practices. As street-level bureaucrats they experience what Lipsky, (1980) refers to as 'role strain' when tasked with enforcing directives that contradict, in this instance, not only their own ethical commitments but the values of the NHS. As Maynard Moody & Musheno argue, misalignment in personal and professional values has the potential to generate moral distress and operational pressure, particularly in contexts where policy undermines professional autonomy and institutional values (Maynard Moody & Musheno 2003; BMA 2023).

The case of the Ugandan woman undergoing an emergency C-section (a surgical procedure, where the baby is delivered through an abdominal incision), as described by Rebecca, offers a clear and troubling example of the ethical tensions introduced by hostile environment policies. The woman, who spoke limited English, was experiencing complications, her baby was breech, and the procedure was urgent. Yet despite the severity of the situation, she was not offered access to Language Line. At the time, Rebecca was confused by this omission, but later realised it was likely a deliberate decision to avoid drawing attention to the woman's immigration status, which could have triggered charging under the Cost Recovery Programme.

The consultant had requested a routine check of her medical history, however, she was not on file, and therefore it became apparent that she may have been classified as an overseas visitor. "It was the elephant in the room," Rebecca explained. "Nobody wanted it to be flagged up."(Appendix,p.38) In this context, we can see a clear discomfort experienced by the clinicians surrounding the outcomes of the policy. The woman's undocumented status placed her in a precarious position, and the staff, aware of the implications, chose not to speak about it. "We all chose not to discuss that patient," Rebecca admitted. "It was awkward." (Appendix,p.39)

This case illustrates what Lipsky (1980) refers to as the fundamental service dilemma, the tension between delivering services efficiently to a large number of people and providing individualised, attentive care. In this instance, the bureaucratic imperative to avoid triggering charging protocols overrode the ethical obligation to communicate clearly and compassionately. This moment of collective silence reflects the ethical paralysis that can occur when clinicians are forced to navigate policies that contradict their professional values. From Rebecca's account it can be speculated that the decision not to use Language Line was not a clinical judgement instead it was a bureaucratic workaround, designed to avoid the

moral discomfort of charging a woman in crisis. But in doing so, it denied her the right to understand her care, to ask questions, and to be treated with dignity living into the fundamental service dilemma discussed by Lipsky. Compared to other patients undergoing similar procedures, her experience was markedly different. “She was dismissed quite a bit,” Rebecca noted. “It was really sad.” (Appendix p.38)

Christine shared a similar experience during a GP placement in mid Wales, where a woman with symptoms of bowel cancer was denied diagnostic tests because she was classified as a non-ordinary resident. “She didn’t get those investigations… I know she never got those tests.” (Appendix, p.197)

Jilke and Tummers’s (2018) model of deservingness cues offers a useful framework. They identify three dimensions, earned, needed, and resource deservingness, which help explain how frontline workers prioritise clients. In both Rebecca and Christine’s cases, the patients clearly met the criteria for needed deservingness, yet their undocumented status undermined their perceived earned deservingness. The administrative complexity of their cases also diminished their resource deservingness, making them less likely to receive care despite clinical urgency.

The cases demonstrate how deservingness heuristics operate in real time. Despite her urgent medical need, the woman’s undocumented status and lack of administrative legibility rendered her less deserving in the eyes of the system. Her care was rationed not based on bureaucratic assumptions about legitimacy. This aligns with Seim’s (2017) concept of a “moral division of tasks,” where frontline workers differentiate between legitimate and illegitimate emergencies. Kohler Hausmann (2018) similarly observes how prosecutors use “heuristics of desert” to ration attention and resources.

Of course, this thesis does not aim to make accusations that are not evidence based, however, it can be speculated that these discretionary practices are not neutral. Headworth (2019) found that welfare fraud investigators often hold stigmatising views of clients and their networks, while Harris (2016) observed that court officials rely on culturally specific values, such as personal responsibility and meritocracy, when deciding how to enforce legal debt. These moral metrics are influenced by race, gender, and class (Watkins Hayes & Kovalsky, 2016; Lara Millán & Van Cleve, 2017), and they are often imported into street level decision making unconsciously. In the data, this was reflected in Craig’s anecdote about receiving faster treatment after identifying as a doctor. “If I didn’t go in my scrub and say I was a

medic, I wouldn't have been seen… you have to play the system sometimes." (Appendix, p.27) This illustrates how perceived legitimacy, earned deservingness, can shape access to care, even among clinicians themselves.

In the case of the woman undergoing a C-section, when asked if Rebecca said anything she admitted she felt she couldn't due to her position as a junior doctor at the time. As a researcher, this case was admittedly intriguing as in this instance, silence actually acted as a form of advocacy, as it evaded the patient's status being checked. Lipsky's (1980) definition of advocacy, which requires street level bureaucrats to use their knowledge, skill, and position to secure the best possible outcome for their clients. However, advocacy is only possible when discretion can be exercised. In this case, for Rebecca discretion was constrained by hierarchy, and for the consultant, it was fear of repercussions, and the bureaucratic logic of the charging system. But the choice to not use language line and as a result not draw attention to the patient's immigration status was a form of discretion as it apposed normal protocol. It can be argued that by staying silent this was a way of securing the best outcome for the patient and therefore advocating in Lipsky's terms. Unfortunately, the result was a failure of care, not due to lack of compassion, but due to structural limitations on moral agency.

Interviewees repeatedly described moments where their professional values were compromised by institutional mandates, particularly in situations involving immigration status, racial profiling, and fee charging regulations. These tensions were most visible in cases where discretion was constrained, advocacy was suppressed, and patients were subjected to differential treatment based on perceived legitimacy.

Lizzie's account of a man with advanced pancreatic cancer exemplifies this conflict. Despite clear evidence on imaging, his diagnosis was withheld while staff attempted to verify his residency status. "It was really sad," she explained. "I was really shocked. I think it's really hard when you disagree with something. But there's this hierarchy… I was in my third year, like I wasn't going to turn around and say something." (Appendix, p.143) Her inability to intervene due to hierarchy was a theme also picked up in Rebeccas account.

Christines similar experience with the woman symptoms of bowel cancer who was denied diagnostic tests because she was classified as an overseas visitor. Like Rebecca, Christine was in training at the time of the case and lacked the authority to challenge the decision. These examples reveal of course the obvious ethical and professional tensions at play. The

interviewee's explicitly state how their opposition to the policy and the outcome of the policy in these contexts, but they were bound by the institutional mandates. But it also sheds light on their ability to use discretion in these instances were prevented by their place within the hierarchy.

Findings & Analysis: Part 2

Discretion and Street Level Divergence in Clinical Practice

The concept of discretion within street level bureaucracy has long been a site of tension and debate. Scholars have offered contrasting normative positions on whether divergence from policy by frontline workers should be viewed as a problem requiring correction (Brehm & Gates, 1997; Jones, 2003; Keiser, 2010), or as a necessary and even desirable feature of democratic service delivery (Behn, 2001; Denhardt & Denhardt, 2000; Evans & Harris, 2004). In the context of the NHS, particularly under hostile environment policies, this tension becomes acutely visible in the everyday decisions of doctors. As seen in the case of the patient undergoing a C-section, practitioners have become active interpreters of policy, often forced to reconcile institutional mandates with ethical obligations to their patients.

As Lipsky (1980) and Maynard Moody & Musheno (2003) argue, street-level bureaucrats operate under conditions of ambiguity, limited resources, and conflicting demands. Their discretionary actions, whether resisting, complying, or adapting policy, are shaped by a complex interplay of professional judgement, moral reasoning, and institutional constraints. This section of the thesis explores how doctors navigate these tensions with discretion, drawing on both interview data alongside observational notes from my time with Patients not Passports.

Discretion as Ethical Judgement

Whilst discretion in some clinical practice may be a neutral or technical function in the context of engaging with fee charging or data sharing policies the data highlighted those who use discretion use it as a moral and political act. For doctors working within the NHS under hostile environment policies, discretion becomes a means of reducing ethical tension. Despite the policy's politically charged nature, it is also where institutional mandates collide with NHS values, i.e. the universality of care, and where practitioners must decide, often in real time, how to reconcile their duty of care with the bureaucratic expectations placed upon them.

Christine, described this conflict with clarity “Policies contradict my moral obligation to treat people according to their needs… I think the problem is the policy, not the patient.” (Appendix, p.231) Her account reflects the ethical strain of being expected to act as an agent of immigration enforcement while simultaneously upholding the principles of universal healthcare, the principles she has been taught to uphold in her professional training. Similarly, as discussed earlier Rebecca spoke of the discomfort she felt when expected to charge patients: “It would make me feel incredibly uncomfortable… It completely undermines the NHS values.” For her, discretion was exercised through quiet resistance, choosing not to enforce charging regulations, even if doing so risked professional consequences. “I probably would turn a blind eye… I don’t know what the repercussions are, but I’d still do it.” (Appendix, p.78) These accounts reflect what Kaptein and van Reenen (2001) describe as ethical divergence, where frontline workers bend or ignore rules to uphold moral principles. In these moments, discretion becomes a form of ethical dissent, a refusal to enact policies perceived as unjust. Linking back to clinicians' perceived obligation to the NHS we can assume these acts of divergence are not solely motivated by individuals' conscience but also the desire to uphold the principles of the NHS.

The concept of moral economy offers a useful lens here. David Hume argued that ethical behaviour is not driven solely by rational calculation or utility, but by sentiments our capacity to feel concern for others and to act on shared understandings of what is right (Hume, 1917/1777: 68). He observed that moral practices often emerge organically, through conventions and shared commitments, rather than through formal promises or abstract rules (Hume,: 207).

This idea is echoed in Bernard Williams’ critique of moral absolutism. Williams argued that ethics should not be reduced to rigid injunctions or universal laws, but must be grounded in the messy realities of human experience our commitments, our emotions, and the tensions we navigate in trying to do what is right (Williams, 1993). He criticised the tendency to moralise, which he saw as a form of secular theology that obscures the complexity of ethical decision making. For Williams, ethical analysis must begin with understanding how people balance conflicting principles in concrete situations, rather than imposing external moral frameworks that ignore the mixture of motives that guide ethical action.

This framing is particularly relevant to the experiences of doctors in the NHS. Natasha, for example, expressed how fear of professional repercussions limits the ability to act ethically

“You’d literally get struck off for doing that… I wouldn’t be comfortable turning a blind eye.” (Appendix, p.299) Her account highlights how institutional structures can constrain moral agency, even when the practitioner feels that the policy is wrong.

Natasha was the only interviewee out of the five interviews who stated they would not turn a blind eye to the fee charging, whilst she still stated she found the policies opposed her ethics as a practitioner the fear of reproductions outweighed her outrage against the policy. However, for those who answered willingly to using discretion as a form of resistance E. P. Thompson’s concept of the moral economy is useful here. Thompson’s analysis of food riots challenged the idea that people act purely out of material need. Instead, he argued that such actions are shaped by shared expectations and a sense of moral outrage by a belief in traditional rights and the violation of fundamental needs (Thompson, 1991). In the context of healthcare, the violation of fundamental needs is the prevention of access to healthcare for migrant patients this suggests that resistance to hostile environment policies whether it's through engagement with organisations such as patients not passports or through quiet resistance, i.e discretion is not just about individual discomfort with the policy, but about a collective sense of injustice and a breach of the moral foundations of the NHS.

James Scott (2000) extended this idea by showing how moral economies can serve as a resource for resistance. He argued that when dominant economic or political practices clash with established values, subordinate groups often draw on moral rhetoric to challenge and resist these changes. In the NHS, this is evident in the activism of groups like Patients Not Passports, who mobilise the language of duty of care, confidentiality, and equity to contest the imposition of immigration enforcement within clinical settings.

Christine’s work exemplifies this kind of resistance. By organising training sessions, challenging health boards, and documenting cases of injustice, she attempts to convert the ethical discomfort of individual clinicians into collective action. “We’re constantly apologising for the state of the service… It wears people down,” (Appendix, p.255) she said, highlighting the emotional toll of working within a system that, in her opinion, fails its most vulnerable.

In addition, Lizzie reflected on what shaped her use of discretion, and it can be interpreted as a mix of emotional labour and relational ethics. “You never really know what someone’s gone through until they’re with you… It’s very easy to fall into the habit of forgetting where patients are coming from when you’re busy.” (Appendix, p.136) I believe the ambition of her

comment was to point out how workload pressures can obstruct tailored care, particularly for migrant patients whose needs may be more complex. But it also seemed to function as a kind of justification, a way of explaining the ethical and practical reasoning behind her decision to act outside formal policy.

It was unclear whether Lizzie felt discomfort in admitting that she had not strictly followed the legislation. However, as an interviewer, I sensed a feeling of unease in her need to justify her use of discretion it was a quiet shame that seemed to signal the moral and professional strain she was experiencing.

On the other hand, Rebecca's reflections were more blazon. She described how her duty of care extended beyond clinical practice "I think we need to advocate for these marginalised groups outside of our own practice." (Appendix, p.55) For her, discretion was not just a quiet act utilised to avoid harm or personal morality, for Rebecca it was more about actively challenging the policy and its motivations.

Discretion as a coping mechanism

Whilst the previous section sheds light on the use of discretion being a moral and ethical response to clinicians' distaste for hostile environment policies. The findings also allude to the clinician's using discretion of a coping mechanism tool. According to Lipsky (1980) Street level bureaucrats, in this case doctors in the NHS, operate in environments where policy implementation is rarely straightforward. As Lipsky (1980) observed, when public rules meet the complexity of real life cases, formal procedures often fall short. In response, SLBs develop coping behaviours to manage the emotional and procedural demands of their role, what Lipsky termed "managing work stresses."

Ellis (2011) refers to this informal prioritisation of easier cases as "creaming," a strategy that helps frontline workers manage overwhelming workloads. Mohammed (2022) expands on this by arguing that SLBs, despite being tasked with immense responsibilities, often reshape their understanding of "good practice" to make the job more manageable. This includes modifying who they see as legitimate beneficiaries and adapting their expectations of care. Winter (2003) suggests that such coping behaviours help reduce burnout, even if they risk distorting the original intent of policy. When Craig discussed the treatment of patients who were asylum seekers, creaming was nonchalantly discussed "There's more needs that they're putting at the back of the pile," (Appendix, p.18) he contested that this was not due to any bias's rather it's the time constraints clinicians are put under and seeing what was regarded as

the ‘easier patients’ i.e those who did not require language line, first is simply more affective. While Craig acknowledged that some clinicians may hold prejudicial views, the more pervasive issue was the absence of support, training, and time. “Most people are not trauma, like care informed, trained anything,” (Appendix, p.18) they said. These reflections point to the ethical tension at the heart of creaming the subtle ways in which equity is compromised, not through overt denial, but through the everyday logistics of clinical practice.

Craig’s experience of working in a refugee clinic in Cardiff sheds light on the emotional toll clinicians are strained by

“It was a very emotional placement… I’ve never felt that heavy of a burden, emotionally drained.” (Appendix, p.8)

He admitted that if asked to charge a patient, he would likely avoid doing so:

“I’d probably end up doing that… I’m not gonna make them pay.” (Appendix,p.3)

Craig’s use of discretion aligns with what Brehm and Gates (2015) term “dissent shirking”, a rational choice to quietly resist policy goals that conflict with professional ethics. But in this case, it also reflects a strategy for emotional self-preservation. During our interview, Craig explained that treating migrants involved additional administrative and communicative labour, such as using Language Line and navigating cultural barriers. He noted

“You need a doctor that has the mental capacity and like emotional capacity left.” “To deal with a patient that's difficult and like way more challenging, which most GPs don't have the time and like capacity for because they're so run down anyway.” (Appendix, p.11)

Here, discretion is not only about resisting policy, it is about managing burnout. Migrants were often perceived as “more difficult,” not due to racial bias, but because of the additional time and energy required to treat them. This perception, shaped by systemic under-resourcing and emotional fatigue, influenced how care was delivered and how discretion was exercised.

Rebecca echoed this emotional strain. She spoke candidly about the psychological impact of hearing patients’ stories

“The stories you hear, they're so harrowing. And you do take it home with you. And it does weigh on you.” (Appendix, p.68)

She acknowledged the need to develop emotional resilience

“You can't avoid hearing about somebody being tortured… not if you want to practise well. So I think that does need to happen, how you look after your own emotional resilience and make sure that you're sustainable in a field like this.” (Appendix, p.68)

The emotional toll described by participants is not isolated. Recent data from NHS England show a record 27 million sick days taken in 2022, with absence rates rising from 4.3% in 2019 to 5.6% (Jerjes, 2025). These figures reflect more than operational strain, they signal a deeper crisis of burnout that has permeated the NHS. General Practitioners (GPs), often the first point of contact for patients, are particularly affected. A 2022 survey revealed that 71% of GPs reported symptoms consistent with severe burnout (The Health Foundation, 2023). The combination of excessive patient loads, bureaucratic demands and emotional labour has left many clinicians at breaking point.

Burnout, as defined by the Society of Occupational Medicine (2023), is not just fatigue, the article suggests it is a chronic response to sustained workplace stress, characterised by emotional exhaustion, detachment and a sense of futility. For doctors, this manifests in subtle but significant ways, withdrawal from complex cases, avoidance of emotionally taxing encounters, and reliance on discretionary judgement to shield themselves from further strain.

Tummers et al. (2015) offer a framework for understanding these behaviours, categorising coping into three families: moving towards the client (serving their interests), moving away from the client (avoiding engagement), and moving against the client (acting in opposition to their interests). In my data, most examples fall into the first two categories. Doctors either quietly resist policy to protect patients or disengage to protect themselves. These strategies reflect a broader pattern of emotional and ethical survival.

Rivera’s (2015) ethnographic study of U.S. Border Patrol agents offers a conceptual lens for understanding how discretion operates as a form of emotional and moral coping. While the occupational context differs, the underlying dynamics of emotional labour, moral taint and identity negotiation are strikingly relevant. Rivera introduces the concept of “emotional taint”, the idea that emotional labour itself can be stigmatised, particularly in roles that are socially or morally contested. Drawing on Hochschild (1983), she defines emotional labour as the management of feeling to produce a publicly observable display, often in service of organisational goals. In law enforcement, as in healthcare, this labour is both expected and undervalued.

Rivera's agents described being trained to suppress emotion, maintain "officer presence," and perform stoicism. Yet many recounted moments of compassion, feeding hungry children, comforting distressed migrants, that were kept private and framed as routine. These acts were not institutionally recognised; however, workers had internalised them as part of the job. The emotional labour required to perform neutrality while absorbing trauma mirrors the experience of doctors treating undocumented patients under hostile environment policies. Both groups operate within systems that demand emotional detachment while exposing them to profound human suffering.

Tracy and Scott (2006) argue that workers in stigmatised roles often develop strategies to manage the moral contradictions of their work. This includes reframing their tasks, distancing themselves from institutional mandates, or engaging in acts of quiet resistance. In my data, doctors described similar strategies. This coping mechanism was especially pronounced among ethnic minority participants, three of whom explicitly linked their discomfort with the policy to their own family histories. Rebecca, for instance, shared

"I suppose I have a personal motivation. My granddad's from Syria and my grandma's from Czechoslovakia… My mum's a first generation immigrant here." (Appendix, p.37) In Rebecca's case her connection to migration shaped her ethical stance and made the policy feel both professionally and personally problematic.

Rivera's use of Weick's (1995) theory of sense making further illuminates how frontline workers construct meaning around their roles. She argues that workers engage in retrospective sense-making, drawing on personal narratives, organisational norms and broader social discourses to interpret their work. This process helps them manage the contradictions of their role and maintain a coherent professional identity. This is particularly noticeable in Rebecca and Christine aligning themselves heavily with the NHS's values or what they refer to as Bevanites' founding principles, a theme discussed in a previous section of this analysis. Grandy and Mavin (2014) similarly emphasise the role of ambiguity in managing moral taint, showing how workers oscillate between pride and guilt to navigate ethically complex roles. In this context, discretion is not just a tool for clinicians to navigate policy, it is also a form of emotional and ethical coping. It allows practitioners to continue working within a system that often contradicts their values, without becoming entirely complicit in its harms.

Discretion, Bounded Rationality, and Institutionalised Ignorance

Until this point, the thesis has approached clinicians as actors who intentionally use discretion to serve either themselves or their patients. It has not yet addressed discretion as a consequence of incomplete knowledge, uncertainty, or what Borrelli (2018) terms "institutionalised ignorance." Simon's (1947) theory of bounded rationality offers a useful starting point: decisions made by street level bureaucrats (SLBs) are rarely optimal. Instead, they are "satisficing" made under conditions of limited information, time pressure, and emotional fatigue. In the context of hostile environment policies, this bounded rationality is not merely a by product of complexity but, in more abstract terms, a structural feature of the system itself.

Borrelli's ethnographic study of migration enforcement bureaucrats introduces ignorance as both a structural and individual phenomenon. Ignorance, in this context, is not merely a passive absence of knowledge, but a condition that is produced, maintained, and sometimes strategically deployed. It can be unconscious, where bureaucrats are kept in the dark by vague or inaccessible policy guidance, or conscious, where knowledge is selectively ignored or withheld by both bureaucrats themselves and governmental bodies. In either case, ignorance becomes a mechanism through which discretion is shaped, justified, and at times, protected.

This resonates strongly with my own findings. None of the doctors I interviewed had received formal training on how to navigate NHS charging regulations or treat non-ordinary residents, despite having trained after the policies were introduced. Craig stated plainly:

"No one's ever covered it, even medicine or all in this degree." (Appendix, p.2)
Natasha echoed this sentiment:
"There's nothing in our training about what to do if someone's undocumented." (Appendix, p.289)

The absence of training sadly reflects a broader institutional failure to prepare clinicians for the realities of working within a healthcare system increasingly entangled with immigration enforcement. Rebecca noted:

"I don't feel knowledgeable on who should be charged… It's a 1,300 page document." (Appendix, p.60)
She also critiqued the superficial nature of equality and inclusion training:

“It’s usually like some online modules, like right at the end of the year… something that you just kind of need to get out of the way.”

This lack of clarity and preparation creates a space in which discretion is exercised under conditions of uncertainty. As Hill (2006) argues, “policy as written often fails to teach implementers what they need to know to do policy.” (P.265) In this vacuum, doctors are left to make decisions based on fragmented knowledge, institutional culture, and personal ethics”.

What is particularly striking is how this ignorance can also be used, consciously or not, as a justification for discretionary action. Rebecca, for instance, was the most informed of all participants. She had intercalated in health inequalities, volunteered weekly at a migrant rights charity, and was actively involved in Patients Not Passports. Yet she still framed her resistance to charging policies in terms of not fully understanding them

“I probably would turn a blind eye… I don’t know what the repercussions are, but I’d still do it.”(Appendix, p.78)

This suggests that ignorance, or at least the performance of it, can function as a protective mechanism. It allows practitioners to exercise discretion while distancing themselves from the legal and institutional risks of non-compliance. In Borrelli’s terms, this is a form of “blinding out”, a selective unknowing that enables moral action within a system that punishes overt resistance.

Borrelli distinguishes between structural and individual ignorance. Structural ignorance is embedded in the design of institutions, through inaccessible policy documents, lack of training, and bureaucratic fragmentation. Individual ignorance, by contrast, can be both passive and active. It includes not only what is not known, but what is chosen not to be known. This distinction is crucial in understanding how discretion operates in the NHS. Doctors are not only under informed, but they are also structurally positioned to remain so.

Natasha reflected on this disconnect between policy and practice

“Most of the time, because I’m quite new, I’ve noticed you don’t actually get taught to do some things until you’re actually expected to do it… and then you ask, how do I do this?” (Appendix, p.296)

This reactive model of learning reinforces the idea that ignorance is not just a gap in knowledge, it is a structural condition that shapes how discretion is used. It also reveals how

doctors are forced to navigate ethical and legal grey zones without institutional support, often relying on informal networks or personal judgement.

Linking back to Tummers et al's. (2015) framework for understanding how coping behaviours emerge in such contexts. They categorise coping into three families: moving towards the client (serving their interests), moving away from the client (avoiding engagement), and moving against the client (acting in opposition to their interests). We can see in this case Doctors either quietly resist policy to protect patients or disengage to protect themselves.

Borrelli's work also highlights how ignorance contributes to the reproduction of structural violence. Drawing on Galtung (1969) and Gupta (2012), she argues that when bureaucrats are kept uncertain or uninformed, accountability is diffused and the system becomes harder to challenge. Migrants, in turn, are subjected to a form of governance that is opaque, inconsistent, and emotionally disorienting. The bureaucratic absurdity of expecting clinicians to interpret and apply over 1,000 pages of charging guidance without adequate training is not just inefficient, it is harmful.

Natasha's comment captures this perfectly

"I have no idea. I feel like it's one of those things, because I've never encountered it… unless I came across it, I wouldn't know what to do." (Appendix, p.296)

This form of ignorance is not benign. It creates uncertainty for both practitioners and patients, and it legitimises inaction. As Borrelli notes, ignorance can be used to neutralise emotionally charged encounters, allowing bureaucrats to process cases without fully engaging with their human implications. In this way, ignorance becomes a form of moral distancing, a way to cope with the contradictions of the role. In this context, we can suggest that discretion and ignorance are intertwined. The lack of training, the overwhelming complexity of policy documents, and the absence of clear guidance all contribute to a system in which ignorance is both produced and performed.

Concealed vs. Transparent Discretion

Discretion isn't always visible. As Wilson (1992) and Maynard Moody & Musheno (2012) argue, frontline divergence can be either concealed or transparent, depending on organisational context and personal choice. Within the NHS, discretion often takes a quiet

form doctors might avoid charging, omit immigration status from records, or delay referrals to protect vulnerable patients. These acts are rarely documented.

Still, discretionary practice is never free floating, one of the key barriers to discretionary practice in the NHS is the institutional expectation of clinical neutrality. In the UK, doctors are trained to be apolitical. As well as being a cultural norm it is also a formalised professional standard. The British Medical Association's ethical toolkit (2025) makes it clear *medical care must be delivered impartially, without regard to a patient's nationality, class, ethnicity, religion, gender, or political belief.* Similarly, the General Medical Council's *Good Medical Practice* guidance warns against expressing personal beliefs, including political ones, in ways that could exploit patient vulnerability or cause distress (GMC, 2024). The NHS Constitution reinforces this ethos, positioning impartiality and political neutrality as central to the delivery of care (Department of Health and Social Care, 2015).

This creates a particular kind of culture within the NHS, one where political engagement is discouraged, even when the policies in question directly affect clinical practice. David Oliver (2019), writing in the *BMJ*, challenges the idea that doctors should be "too politicised." He argues that medical professionals have always played a role in shaping public health policy, from campaigns on smoking and air pollution to critiques of Brexit's impact on healthcare. His piece highlights the contradiction doctors are expected to remain neutral, yet they work within a system that is political in its nature.

This contradiction is reflected in the accounts of clinicians who quietly support activist networks such as Patients Not Passports or Docs Not Cops, but do so discreetly, often without disclosing their involvement to colleagues or patients. During my time observing Patients Not Passports meetings, repeated invitations to interview members were declined. Many expressed concern that if this thesis were made public, their association with the group could be exposed, potentially jeopardising their professional standing or relationships within the NHS.

What emerges is a tension between the formal expectations of neutrality and the reality of ethical discomfort the clinicians are experiencing. Doctors are positioned as neutral caregivers, yet they are asked to implement policies that undermine the principles of care. This tension is central to understanding how hostile environment policies are enacted in practice, not just through legislation, but through the quiet, conflicted decisions of those tasked with implementation. My observations of Patients Not Passports meetings revealed a

culture of caution and concealment. Despite clarifying that I would only be observing, I was asked not to record their meetings. There were moments of shushing when members discussed cases where they had chosen to ignore patients' immigration status or charging protocols. This reluctance to speak openly reflects a deeper tension the fear that exercising discretion might conflict with the clinical neutrality they've been trained to uphold.

Christine's interview captured this unease. She described how colleagues would respond to campaign invitations with a heart emoji but rarely attend events or engage in discussion. "It often surprises me how apolitical doctors seem to be,"(Appendix, p.261) she said, noting that many support causes privately but avoid expressing political views in the workplace. It is plausible to suggest the secrecy and silence around opposition to the policy is not incidental but it is quite possibly cultivated through professional norms that discourage overt political engagement (GMC, 2024; BMA, 2025).

Cheraghi Sohi and Calnan's (2013) study offers a valuable framework for understanding this dynamic. Their research aimed to examine how professional discretion among GPs in England has been reshaped by new governance mechanisms, particularly the Quality and Outcomes Framework (QOF). Rather than assuming a straightforward decline in autonomy, they explored how discretion is reconfigured across five dimensions: bureaucratic, social, organisational, economic, and political. Their findings suggest that while certain aspects of clinical work have become more visible and standardised, especially through ICT systems and performance targets, practitioners still retain significant task discretion, particularly in how they interpret and apply guidelines within consultations.

This is especially relevant in the context of hostile environment policies. Craig described avoiding questions about immigration status "That is not important for the care I'm going to be providing." (Appendix, p.22) Rebecca similarly noted that she would ignore charging requirements if it meant safeguarding patient welfare (Appendix,p.78). These decisions reflect what Cheraghi Sohi and Calnan (2013) describe as the persistence of discretionary judgement, even under increased surveillance and managerial oversight. Their study found that while GPs were subject to new forms of scrutiny, many continued to negotiate between institutional demands and patient centred care, often resisting top down directives in subtle ways.

Yet discretion is not always hidden. Christine's activism with Patients Not Passports exemplifies how discretion can be made visible as a form of resistance. She organised

training sessions for consultants, encouraging them to reflect on the ethical implications of immigration enforcement in healthcare. “Some consultants joined the campaign after our training session,” (Appendix,p.233) she recalled. Rebecca, too, described her duty of care as extending beyond clinical boundaries “We need to advocate for these marginalised groups outside of our own practice.” (Appendix,p.55) In these instances, discretion becomes a tool for reform, challenging the legitimacy of policies that undermine care.

During meetings, I observed members drafting formal letters to health board chairs, opposing increased pressure on clinicians to police residency status. One message shared in the group chat read *“Joint Letter Challenging Hywel Dda Health Board’s Push for Migrant Charging… signed by members of Patients Not Passports Wales and other comrades within Wales.”* The use of terms like “comrades” and references to “redeploying” the Overseas Visitors Team framed the issue in distinctly militant terms, positioning NHS staff as defenders of a vulnerable institution under siege. The NHS was repeatedly described as something to be protected almost like a damsel in distress and the clinicians involved as crusaders willing to challenge the erosion of its founding principles.

This rhetorical framing reflects what Cheraghi Sohi and Calnan (2013) describe as the political dimension of professional discretion. Their study revealed that discretion is not simply about clinical autonomy it is shaped by bureaucratic systems, internal hierarchies, and professional cultures. In activist spaces like Patients Not Passports, discretion operates across these same dimensions. The decision to resist charging protocols or withhold immigration status is not just a clinical judgement, it is a political act.

Cheraghi Sohi and Calnan’s findings also highlight how discretion is shaped by internal hierarchies and practice cultures. Their study revealed that QOF teams and lead clinicians often directed the work of others, creating new forms of accountability and surveillance. Yet even within these structures, GPs found ways to interpret guidelines flexibly, prioritising patient welfare over rigid compliance. This mirrors the way doctors respond to hostile environment policies negotiating between institutional mandates and moral obligations, often in ways that are informal, undocumented, and emotionally taxing.

Conclusion

This thesis centred on how NHS doctors navigate hostile environment policies in their everyday clinical practice, focusing on the ethical dilemmas, discretionary strategies, and

institutional constraints that shape their responses. Drawing on semi-structured interviews with five clinicians in South Wales and participant observations of Patients Not Passports meetings, the study examined how frontline healthcare workers interpret and respond to immigration enforcement measures embedded within the NHS.

Guided by the main research question *How do NHS doctors navigate hostile environment policies in their everyday clinical practice?* Alongside three sub questions, the thesis applied the lens of street-level bureaucracy (Lipsky, 1980) to understand how discretion operates as both a moral and practical tool. The findings reveal that the doctors interviewed are not passive implementers of fee charging rather, they use case by case decisions about how the policy should be applied in practice whether it is working around the policy to suit the patients' needs or resisting its directives in order to uphold clinical ethics and protect patient welfare.

In response to *Sub RQ1: What ethical dilemmas arise for doctors when navigating the intersection of healthcare and immigration enforcement?*, the study found that clinicians frequently encountered situations where policy demands conflicted with their duty of care. For instances the account of Lizzie and Christine who described cases where patients showing signs of cancer were denied diagnostic tests due to their immigration status. The exploration of these cases in the analysis shed light on how morally unsettling these interactions were and ultimately revealed the tension between bureaucratic compliance and clinical ethics.

A recurring theme was the alignment of clinicians' values with the founding principles of the NHS, often referred to as Bevanite values. Doctors viewed fee-charging and data-sharing practices as fundamentally incompatible with the NHS's ethos of universalism and equity. This sentiment extended beyond individual clinicians to activist collectives such as Patients Not Passports, whose members described themselves as "defending the NHS" against policies they saw as discriminatory and harmful.

In addressing *Sub RQ2: What strategies do doctors employ to reconcile professional obligations with the demands of hostile environment policies?*, the thesis found that discretion was the most commonly used tool. Four out of five interviewees described "turning a blind eye" to immigration status.

Discretion took multiple forms. Some clinicians used selective ignorance, avoiding documentation or eligibility checks. Others engaged in what Ellis (2011) terms "creaming,"

informally prioritising patients who were easier to treat without bureaucratic complications. A few participants described openly contesting the policy, including writing formal letters to health boards refusing to engage with charging protocols.

In response to *Sub RQ3: How do institutional constraints and personal values shape the way doctors interpret and respond to these policies?*, the study found that personal histories particularly among ethnic minority clinicians played a significant role. Participants explicitly linked their discomfort with the policy to their own family migration experiences. Rebecca, for example, described the policy as "personally offensive," noting that it undermined both her professional ethics and her sense of identity. Rivera's use of Weick's (1995) theory of sensemaking helped illuminate how clinicians construct meaning around policy ambiguity, often drawing on personal narratives to guide moral decision-making.

Institutional expectations of neutrality further complicated these responses. Doctors described feeling silenced, with some avoiding any discussion of the policies in clinical settings. Members of Patients Not Passports reported keeping their involvement secret, fearing professional repercussions. This culture of silence contributed to the concealment of discretionary practices, making resistance difficult to trace but no less significant.

With all the findings taken into account, they suggest that the nature of the policy's intent and the way it is rolled out is not appropriate for a healthcare environment. In their professional training, doctors have been conditioned into values that fundamentally oppose the nature of the policy. It also sheds light on the fact that, despite clinicians being trained to remain politically neutral, it is difficult for them to truly place personal political opinions and morality aside.

A limitation of this study is the narrow range of interviewees. For instance, there was little variation in the opinions and attitudes expressed. Whilst this may reflect widespread opposition to the policy within clinical spaces, it could also suggest that the research sample was not broad enough to capture more polarised or dissenting views. Including perspectives from clinicians in different regions, specialisms, or institutional settings may have revealed greater diversity in how the policy is interpreted and navigated.

An intriguing direction future research could go down is investigating how Labour's structural shift of the NHS , particularly its attempts to decentralise power affects the implementation of hostile environment policies. This could offer insight into how changes in

governance shape frontline accountability and the consistency of policy enforcement across different regions or Trusts.

Regardless of where future research leads, the current reality demands that policymakers confront the ethical consequences of embedding immigration control within clinical care. To move towards a more ethical and sustainable healthcare system, future policy must address the reality of what hostile environment measures demand from clinicians. The findings of this thesis show that these policies are not just difficult to implement they are fundamentally at odds with the values doctors are trained to uphold. If immigration enforcement continues to be embedded in clinical spaces, the quiet resistance of frontline staff may no longer be enough. What is needed is a serious re-evaluation of how care is defined, and whether the NHS can continue to claim universality while enforcing exclusion at the point of treatment.

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