



trafficking arranged for her release.

It was later revealed that Ms. Z. had been arrested because Nurse M. had called the police, believing that undocumented immigrants were “illegal” and did not

deserve care. The nurse’s action was a direct response to recent training she’d attended about a new NHS Visitor and Migrant Cost Recovery Programme that restricts free access to hospital care for migrants. Nurse M. felt

responsible for protecting the health service from abuse by migrants who were said to be attracted to the United Kingdom because of its health and welfare system.

### Case B: Baltimore

In Baltimore, D., a 3-year-old boy born in the United States to undocumented Mexican parents, visited a pediatrician’s office for follow-up on his significant speech delay. His mother, Gloria, told the pediatrician that Immigration and Customs Enforcement (ICE) agents had recently come to their house, searched the backyard, and pounded on the doors. She had remained silently hidden inside, and eventually the agents had left. Assuming that ICE was randomly targeting the homes in the neighborhood because of the high concentration of immigrant families, Gloria moved her family to a predominantly non-Hispanic neighborhood. Their new home, however, was far from the pediatrician and critical early-intervention services for children with developmental delays.

Recognizing the potential ramifications of parental deportation for D.’s well-being, the pediatrician provided the family with “know your rights” materials covering the basic legal entitlements for undocumented immigrants in

the United States. Another clinician, however, reported the pediatrician to the hospital’s legal office for distributing this information to immigrant families. The legal office admonished the pediatrician,

citing concerns about the scope of clinical practice for physicians. The legal staff questioned the significance of the parents’ risk of deportation to the child’s health and well-being.



### Social Analysis Concept: The Right and Left Hands of the State

Medical professionals serve a number of “parastatal” functions, actions partly of and for the government: they sign birth certifi-

cates and death certificates, determine eligibility for disability benefits and paid sick leave, and fill other roles that intersect with

the work of municipal, state, and national governments. The sociologist Pierre Bourdieu grouped these state functions into two

**The right and the left hands of the state, a concept developed by the sociologist Pierre Bourdieu, represent the punitive or policy forms of governance, on the one hand, and the therapeutic or welfare modes of governance, on the other. The clinic serves many functions that mediate between patients and local and national governments, and it is vital for clinicians to understand when they are serving a therapeutic role and when they may be playing a punitive one.**

main categories, which he called the “left hand” and the “right hand” of the state (see box).<sup>1</sup> In nations like the United States and the United Kingdom, the left hand of the state encompasses therapeutic services such as education, health care, food support, public housing, and social assistance that protect and expand life choices, providing relief to vulnerable people. The right hand of the state serves punitive functions such as justice, police, correctional, and regulatory operations that control deviance and enforce discipline.

Understanding these two “hands” can help clinicians recognize and map the roles that health care professionals play when we mediate between patients and state organizations: Are we act-

ing as an agent of a therapeutic form of governance (the left hand) or a punitive form (the right hand)?<sup>1</sup>

In the United Kingdom, health care has been a universal public benefit since 1948. In contrast, in the United States, access to health care is usually mediated by market forces as employee benefits, with limited state entitlements. The specific exclusion of undocumented immigrants from the Affordable Care Act (ACA) was rationalized with the argument that people who have broken the law do not deserve benefits. In 2016, the United Kingdom also began restricting NHS care on the basis of migrant status. Responding to popular fears that universal health care served as a magnet for an influx of undeserving outsiders, political leaders introduced policies that prioritized disciplinary mechanisms to create a hostile environment for immigrants.

In the cases of D. and Ms. Z., the right and left hands of the state were in tension: clinicians’ efforts to use medical resources to address the added health risks faced by undocumented migrants conflicted with institutions’ efforts to comply with increasing expectations of police presence and use of clinical spaces as sites of detention and deportation. As the cases demonstrate, state-derived codes regarding citizenship and legality impinge on health care delivery by regulating as-

pects of professionalism and restricting access to care. On the one hand, physicians routinely support patients by, for example, documenting disabilities and advising on rights to health care and other benefits. On the other hand, the state can recruit clinicians to police health care access by people perceived as undeserving. With shifting governance priorities and expanding networks of regulatory control, health professionals may come to believe that it’s their duty to enact punitive immigration policies. It was a clinician, not a security agent, who called the police to detain Ms. Z.; and it was a fellow clinician, not a lawyer, who reported the pediatrician for providing “know your rights” information to D.’s undocumented parents.

The presence of punitive governance in the clinical setting complicates clinicians’ ability to fully advocate for the welfare of their patients, especially when health professionals become enforcers of that power. When the clinic serves as a site for police action instead of care and welfare, access becomes contingent on citizenship, not personhood. Health professionals can find themselves acting as agents of the punitive state, turning patients into deportees. Health professionals who resist this role, such as the Baltimore pediatrician, may be subject to sanction.

## Clinical Implications

Faced with such unsought entanglements, clinicians can take some important steps to protect their

patients and their own professionalism and values.

1. Recognize the relationship be-

tween the state and medical care. Clinicians serve key functions that mediate between patients and the

state, in both supportive and punitive roles. Awareness of how these roles change over time helps clinicians to be vigilant about moments when new responsibilities to the state conflict with clinicians' fiduciary responsibilities to their patients.<sup>2</sup>

2. *Prioritize the clinical mission.* Clinicians have a fiduciary responsibility to act in their patients' best interests. When they encounter clear threats to a patient's well-being, even if those threats appear to be outside the scope of immediate and conventionally constructed medical care, clinicians can prioritize actions that improve health by mitigating effects of harmful structures and policies. Such actions may include offering direct guidance regarding the right to care within the clinical setting, even if there is organizational pressure to do otherwise.

3. *Engage in resistance through organizational advocacy.* Clinicians and the organizations they work for are often subject to competing priorities. In the face of such conflicts, individual action may

be best directed at seeking and leading a collective, organizational reassessment of priorities — which can be effective in advocating for specific patient groups. For example, some clinics and hospitals appropriately train and support staff to work within ethical codes of care and declare their services a sanctuary for patients. Some institutions may take steps to limit the impact of surveillance policy, as is increasingly done by health care providers in Britain and California, who register patients without asking for identification or who use the health care facility's address as patients' mailing address.

4. *Integrate legal training and collaboration into clinical practice.* Being threatened with detention or deportation affects people's health.<sup>3</sup> Addressing these threats in the clinical encounter is therefore within a clinician's scope of duty, as long as it's clear to patients that the information they provide to health care professionals will not be used in ways that can harm them. Educating physi-

cians to recognize the health needs of vulnerable migrants, such as children of undocumented-immigrant adults and survivors of trafficking, is the first step.<sup>4</sup>

Also key is for health care organizations to support legal and advocacy training for primary care practitioners and to offer patients referrals to and information about local organizations that provide trustworthy information. Clinicians can provide medicolegal reports to support asylum applicants, in collaboration with immigration lawyers and nongovernmental organizations.<sup>5</sup>

Health care professionals trained to think critically about their relationship with shifting governance priorities can more easily recognize when a given policy may be turning them into instruments of exclusion and punishment. This tension warrants resistance from individual clinicians and professional groups to maintain the integrity of the medical code of ethics.

## Case Follow-up

When Ms. Z's immigration lawyer reviewed her case, he advised Ms. Z. to sue the hospital because Nurse M. had breached her confidentiality by calling the police. Ms. Z. chose not to sue and simply sought an apology and assurance that hospital staff would be trained so that "this would not happen to others."



An audio interview with Dr. Berlin is available at [NEJM.org](https://www.nejm.org)

The Baltimore pediatrician challenged the sanction and presented the case to the hospital ethics committee, which ruled in favor of distributing "know your rights" materials in the clinic, given the well-documented negative effects of family separation due to deportation on children's health and well-being.

The story of Ms. Z. is based on more than one case; identifying details have

been omitted in the story of D., to protect the family's privacy.

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## Sodium-Intake Reduction and the Food Industry

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A recent report from the National Academies of Sciences, Engineering, and Medicine (NASEM) on dietary sodium intake adds overwhelming weight to the already strong imperative to reduce the amount of sodium in the U.S. food supply.<sup>1</sup> Some food companies had used the ongoing work on this report as a reason to slow sodium-reduction efforts, citing the possibility of substantial changes to existing conclusions about sodium and health. The report, however, confirms that sodium intake among adults should be reduced from an average of 3400 mg per day to 2300 mg per day and links excess sodium intake to cardiovascular disease, hypertension, and stroke — chronic conditions that have staggering direct and indirect costs in the United States. The report gives due consideration to the evidence presented in arguments against reducing sodium intake and concludes that there is no harm associated with such dietary changes.

Public health initiatives to re-

duce population-level sodium intake date back more than 40 years. Ten years ago, the obvious failure of these initiatives led federal health agencies to commission a report from the Institute of Medicine (IOM, now the National Academy of Medicine) on strategies for reducing sodium intake in the United States.<sup>2</sup> The IOM's 2010 report (on which two of us collaborated) concluded that U.S. consumers couldn't meaningfully reduce their sodium intake by means of food selection and modification of salt use in the home, since only about 5% of sodium intake comes from salt added at the table or during home cooking and nearly 80% comes from sources over which consumers have little control, including processed and restaurant foods with added sodium (the other 15% comes from foods that naturally contain sodium).<sup>2</sup>

The IOM therefore recommended comprehensive but gradual reductions in sodium throughout the food supply. Such reductions were to account for

the safety, quality, and taste functions of sodium in various foods and consumers' need to adapt to lower sodium levels. The report sought to create an even playing field for food manufacturers and restaurants by recommending that the Food and Drug Administration (FDA) begin a process of setting mandatory sodium standards. It encouraged the FDA to partner with the food industry because of the agency's expertise and its regulatory authority over substances added to food. The report recommended an approach based initially on dialogue, research, voluntary sodium reductions, and frequent evaluation and monitoring, to be followed by regulatory limits on sodium in processed and restaurant food when necessary to ensure safety.

Under the FDA's food-additive law, there are typically two ways substances can be safely and lawfully added to food. A substance can be approved by the FDA under a safety standard that requires scientific evidence es-