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HEALING AT THE MARGINS: A CULTURAL/HISTORICAL PERSPECTIVE ON INTERNATIONAL MEDICAL GRADUATES IN THE US HEALTHCARE SYSTEM

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HEALING AT THE MARGINS: A CULTURAL/HISTORICAL PERSPECTIVE ON INTERNATIONAL MEDICAL GRADUATES IN THE US HEALTHCARE SYSTEM

by

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Dedication

To my family

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HEALING AT THE MARGINS: A CULTURAL/HISTORICAL PERSPECTIVE ON INTERNATIONAL MEDICAL GRADUATES IN THE US HEALTHCARE SYSTEM

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Foreign, or international, medical graduates make up about twenty five percent of current American medical trainees and twenty percent of physicians actively practicing medicine in the United States. In some specialties, particularly in primary care, the percentage of residents who received their medical education abroad nears fifty. Furthermore, international medical graduates or IMGs, known as foreign medical graduates or FMGs before the mid-nineteen-nineties, are far from a novel presence within the American medical center, often credited with disproportionately caring for indigent, urban, institutionalized, and rural Americans. The presence of these physicians, however, has also long been controversial, engendering suspicion from organized medicine and concerns from policy analysts about physician surpluses in the United States and a "brain drain" of needed medical talent from much poorer nations. The past, current, and future role of IMGs is a window into American medicine from its margins. Through a historical and narrative exploration this project re-evaluates the role of medical migrants in the academic medical center and American medical practice since World War Two, arguing that the presence of these physicians has had a material impact on the nature and development of the US healthcare system, masking many of its safety-net shortfalls. Through qualitative analysis, I also delve more deeply into the relationship of migration and professional identity that has evolved within American medicine and global medicine throughout the Twentieth century. The United States has not simply functioned as a passive recipient of immigrant clinicians from across the world but has also been a progenitor of powerful ideologies and policies that have had complex and often unintended effects on clinician migration.

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AAMC	American Association of Medical Colleges
ACGME	Accreditation Council for Graduate Medical Education
AMA	American Medical Association
AKU	Aga Khan University
ECFMG	Educational Commission for Foreign Medical Graduates
FMG	Foreign Medical Graduate
GME	Graduate Medical Education
IMG	International Medical Graduate
IRB	Institutional Review Board
NBME	National Board of Medical Examiners
PUMC	Peking Union Medical College
US IMG	US-born International Medical Graduate
USMG	United States Medical Graduate
USMLE	United States Medical Licensing Examination
UTMB	University of Texas Medical Branch

Introduction

Every year, thousands of physicians from all over the world apply to American residencies and fellowships. In 2015 this group included highly motivated and competitively trained medical school graduates from places as disparate as India, Pakistan, China, the Philippines, Jordan, Egypt, and Nigeria, among over 100 other countries.[1] [2] Many of these physicians remain in the United States for the duration of their training and beyond. For each one of these applicants, what it means to train in the United States is determined by a complex matrix of conceptions and values about medicine, citizenship, care, and identity. These physicians have also been assigned an overlapping web of meanings and interpretations by the Americans who hire them into residency programs, work with them on the wards, and go to them as patients. Foreign, or International, medical graduates make up about 25% of American medical trainees and 20% of physicians actively practicing medicine in the United States. In some specialties, particularly in primary care, the percentage of residents who received their medical education abroad nears 50%.[3] [4] Furthermore, International Medical Graduates or IMGs,

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[1] "IMGs in the United States," American Medical Association, accessed July 15, 2015, http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates/imgs-in-united-states.page?

[2] "ECFMG | Resources: Data - ECFMG Certification." Educational Commission for Foreign Medical Graduates, accessed July 15, 2015, http://www.ecfmg.org/resources/data-certification.html.

[3] "International medical graduates in American medicine: contemporary challenges and opportunities," American Medical Association IMG Section Governing Council. Chicago: American Medical Association; 2010, Accessed August 9, 2013, http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf.

[4] The term IMGs, or international medical graduates is sometimes used to refer to all physicians in the US who have completed medical school abroad. This would include both foreign nationals who received their medical degrees in their countries of origin (or other countries excluding the US and Canada) as well as US nationals who have gone abroad specifically to obtain a medical degree (this includes many graduates of Caribbean medical schools). This dissertation is primarily concerned with the former group. When appropriate, these two groups are distinguished as non-US IMGs (or F-IMGs) and US-IMGs respectively. Canadian graduates are generally not considered IMGs for statistical and study purposes as Canadian medical schools largely share academic and accreditation structures with the US.

known as Foreign Medical Graduates or FMGs before the mid- 1990s,[5] are far from a novel presence within the American medical center, with some residency training programs graduating 30% FMGs as early as the 1950s.[6] Despite these impressive numbers, this group of physicians have been curiously invisible to the fields studying medicine and medical education in its social and cultural context such as the history of medicine, medical sociology, medical anthropology, and of course, the medical humanities. This dissertation asks why the stories and experiences of IMGs are disproportionately missing from the consciousness of American medicine and the disciplines that study it, and responds by gathering these stories through literary, historical, and qualitative methods, examining how they nuance, question, and diversity mainstream discourses about American medicine.

THESIS

Through the combined analysis of historical sources, published narratives, and qualitative interviews, this project presents several intertwined arguments about the relationships between Internationally-trained physicians and the US healthcare system as well as the identities of these clinicians both as physicians and as immigrants. Broadly, I argue that the United States health care system has had a contradictory and often dysfunctional relationship with the internationally trained physicians that have been essential to it for generations. International medical graduates, particularly in their roles as trainees, have filled essential gaps in care provision, particularly within its patchwork safety net. Although this role has been subjected to exhaustive statistical analysis over the

[5] Shawn McMahon. *Fight for Equality: International Medical Graduates in the United States* (Washington, D.C.: Potomac Publishing, 2005), 90.

[6] Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. (Oxford, UK: Oxford University Press, 1999), 315-316.

years, it has not as yet been elicited historically, nor has rigorous, critical attention been paid to the rhetorics that surround these clinicians. Internationally-trained physicians are alternately subject to intense scrutiny or become seemingly invisible to the public and professional consciousness. It is this process, I argue, that renders them a flexible labor force. Tracing how these roles have evolved over time and become intertwined with the structures and institutions of American medical education and health provision reveals that these physicians have filled not only substantive gaps in physician labor, but also ideological gaps in the ways American physicians, legislators and patients think about healthcare. The first few chapters of the dissertation, therefore, draw on published narratives of IMG experiences and on historical sources to sketch out how the availability of foreign-trained physicians eager to practice in the United States has allowed American legislators, organized medicine, and medical educators to avoid larger questions about cherished philosophies of training healthcare providers. A prominent example of this has been the persistence of the ideologies of the 1910 Flexner report, which has led to the systematic undertraining of physicians to meet American healthcare needs—and a tacit policy of recruitment from abroad, even as these physicians are periodically decried as opportunists and threats to physician livelihoods and patient welfare. This ready supply of physicians has allowed American medical leaders and legislators to avoid searching questions not only about whether they are training enough clinicians, but also whether they are training clinicians for the public good, willing and able to work in "unglamorous" specialties and among needy populations; and whether the American system of medical education and post-graduate training is truly capable of providing the diversity among clinicians needed to effectively serve the US population. More broadly

this seemingly bottomless pool of eager clinicians forecloses questions about how the US healthcare system makes use of resources, both material and human.

Defining the very questions that I seek to answer in this dissertation had been a process of continual revision and reassessment as perspectives from my historical sources, and conversations with internationally-trained physicians themselves have lead me to question what I thought I knew. I initially set out to answer what I felt was a sufficiently broad question: "How has this group of physicians affected the US healthcare system?" I soon discovered, however, that this was only one part of larger story, a story I could not tell fully without conversely examining the impact of American medicine on physicians globally. I found it necessary to broaden my lens in order to encompass the historical context of the globalization of biomedical education and the changing roles and meanings of migration throughout the 20th century. Perhaps the first thing that surprised me was the historical scope of this project. As I discovered, I am not the only researcher who set out to study immigrant clinicians in the United States with the logical, but ultimately short-sighted assumption that the story I sought to tell began with the US immigration reforms of 1965, which many scholars have held to be the seminal turning point that opened US immigration to citizens of the "third world."[7] Catherine Ceniza Choy, in her 2003 monograph, *Empire of Care*, a history of Filipino nurses in the United States, argues that this assumption "marginalized Asian professional migrations."[8] She found, as I did, that the historical origins of health professional migrations crossed national boundaries and were deeply entwined with colonial and post-colonial histories.

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[7] David M. Reimers, *Still the Golden Door: The Third World Comes to America* (New York, NY: Columbia University Press, 1992). 1.

[8] Catherine Ceniza Choy. *Empire of Care: Nursing and Migration in Filipino American History* (Durham, NC: Duke University Press Books, 2003), 3-4.

Thus I had to delve more deeply into the relationship between migration and professionalism that has evolved within American medicine and global medicine throughout the 20th century. The United States has not been a passive recipient of immigrant clinicians from across the world, but also a progenitor of powerful ideologies and policies that have had complex and often unintended effects on clinician migration. Chapters five and six apply a critical historical perspective to American medical education as a global enterprise, demonstrating how medical education has been entangled with projects of colonialism, nation-building, and the entity of "development." Unpacking some of these heritages brings insight into the factors that often foreclose many possibilities outside of migration to wealthy nations such as the US for global physicians.

This dissertation seeks to present migrant and immigrant clinicians not as abstractions mechanically responding to outside forces and pressures, but as individuals who negotiate identities as physicians, as immigrants, as members of various communities, and as members of families. They are individuals who make choices based on the situations, possibilities, and logics available to them. The final two chapters of this dissertation will draw on interviews with International Medical Graduates training and practicing in the United States. Coupled with pervious discussions of historical background, these explorations give insight into the complex motivations that bring physicians to the United States as well as into ways that they see themselves as clinicians—entwined phenomena I call the "American medical dream." These chapters also flip the lens around, from looking at the ways IMGs are perceived in the US healthcare system to examining the perspectives they themselves bring to practicing in

the United States. Psychiatrist and anthropologist Arthur Kleinman describes his work as "writing at the margin," articulating a manifesto for critical advantage of working between disciplines and understandings, and using views from the periphery to challenge the common sense of the mainstream.[9] In multiple ways these physicians have spent time working at the margin of the US healthcare system. Although many of them see themselves as American physicians, they have experience practicing medicine in at least two if not more healthcare systems and often find they have to reformulate some of their understandings of their roles as physicians. Likewise, many of my interviewees have worked in less popular specialties and locations, often treating populations that are themselves considered marginal. Their perspectives inform important critiques of US healthcare and medical education and deserve attention from medical humanists, medical educators and others looking to change some of medicine's structures and practices without sacrificing its patient-centered ethic.

LITERATURE REVIEW AND CHAPTER STRUCTURE

One of the paradoxes I encountered in my initial literature review for this dissertation is that International Medical Graduates are in some ways incredibly controversial, and practically invisible in others. Thus, this project is by its nature interdisciplinary because of the fragmented nature of the conversations it is joining. On one level, the very label of "alien," "foreign," or "international" as it has been applied to physicians deserves discussion. There is no innate reason to suppose national origin as an important factor in the professional roles and identities of clinicians. As I touch on

[9] Arthur Kleinman, *Writing at the Margin: Discourse Between Anthropology and Medicine* (Berkeley and Los Angeles, CA: University of California Press, 1995),1.

briefly, in other national and historical contexts, being a physician-migrant has had very different meanings. Thus International Medical Graduates matter as a category because of the stakes embedded in the reification of that category for those who create it and those who identify with it. IMGs have periodically been a subject of interest within the American medical profession itself, in medical education circles, for scholars of health policy, especially those interested in "physician supply," or "medical workforce issues," and more recently for scholars in the field of global health. Other fields, however, have, perhaps surprisingly, not seemed to have much awareness or engagement with this issue; among these are bioethics, medical humanities, and the history of medicine. As I will argue in this dissertation, given the richness of the issues a closer look at IMGs engages, this omission is both unfortunate and rife for correction.

A historical review of major medical journals including The *Journal of the American Medical Association*, *The New England Journal of Medicine*, and *Medical Education*, reveals long stretches of time where discussion of IMG issues seemed to at best be considered a niche interest or an afterthought to other questions. These stretches are punctuated by moments of controversy, with articles and letters to the editor alike bordering on frank invective. As forums for voices from the American medical mainstream, these publications have reflected the bias of many published discussions on migrant physicians in the United States: the question of whether or not they are a professional threat to American-trained clinicians. Historically, the issue of foreign-trained physicians in US healthcare first became controversial in the 1930s and 1940s, with the influx of mostly Jewish physicians fleeing Nazi-controlled European countries. Although the anxiety expressed in the pages of American medical journals cooled after

the war, perhaps the fiercest reaction against foreign-trained physicians took place in the mid-1970s, a time of great change in the US healthcare system and the societal roles of physicians, as well as a period of major shifts in US immigration policy, with the bulk of immigrants transitioning from working class Europeans to professionals from Asia and the Middle East. Numerous articles appeared in *JAMA* and the *NEJM*, alleging that foreign medical graduates constituted a dangerous "medical underground," of poorly trained "third world" doctors "delivering medical care in an unsupervised and unregulated fashion."[10] This discourse resurfaced again in the 1990s, as fears of a physician surplus once again lead some American medical leaders to construe this group of physicians as a threat. These accusations, however, engendered responses, countering that perhaps it is not foreign trained physicians that exploit the US healthcare system, but that the system, and its American clinicians, do in fact derive a great deal of benefit from IMGs in the United States.[11] One of the major foci of this project is a reflection on how the American medical mainstream has related to the internationally-trained physicians that have become essential to its functioning. Thus I will explore these moments of controversy in greater detail in later chapters as well as a place them in their appropriate historical contexts.

More current discussions of IMGs in the medical literature have been somewhat more prominent in the sub-literatures on rural health and primary care. For example, scholars in rural health have been interested in the IMG issues for several decades, as this group of physicians have made up an important part of the physician workforce serving

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[10] R J Weiss, J C Kleinman, U C Brandt, J J Feldman, and A C McGuinness, "Foreign Medical Graduates and the Medical Underground," *The New England Journal of Medicine* 290, no. 25 (June 20, 1974): 1412.

[11] Counsel on Graduate Medical Education, "International Medical Graduates. Immigration Law and Policy and the U.S. Physician Workforce. Council on Graduate Medical Education Resource Paper. A COGME Panel Discussion (Washington, DC, March 12, 1996).," January 1997. http://eric.ed.gov/?q=COGME+1996&id=ED428636.

rural communities across the United States. A 2007 study published in the *Journal of Rural Health*, for example, notes that nearly half the rural primary care physicians in Florida were foreign-born and foreign-trained. Thus, this article argued in support of policies such as the Conrad-30 program, which allows for visa waivers for foreign-trained clinicians who spend time practicing in America's rural areas.[12] Discussions about the educational needs of IMGs have been more prominent in the journals of primary care specialties such as Family Medicine and Internal Medicine. To some extent, this is in keeping with the fact that these specialties train a disproportionate number of international clinicians. Many of these articles emphasize aspects of "acculturation" and "practice socialization" as normative educational goals within US residencies that train large numbers of IMGs. [13] [14]

Other articles in this same genre include assessments by American medical educators of the degree to which IMGs learn to conform to practice values held to be characteristically American. One such 2009 study, for example, compares the score of IMGs and USMGs completing Internal Medicine residences on a questionnaire designed to assess professionalism, with the goal of determining whether IMG residents "have at least begun development of the 21st century tenets of medical professionalism."[15] From one perspective, these studies make sense as pedagogical tools geared toward the needs

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[12] Robert G. Brooks, Russell Mardon, and Art Clawson, "The Rural Physician Workforce in Florida: A Survey of US- and Foreign-Born Primary Care Physicians," *The Journal of Rural Health,* 19, no. 4 (2003): 486.

[13] Gerald P. Whelan, "Commentary: Coming to America: The Integration of International Medical Graduates into the American Medical Culture." *Academic Medicine: Journal of the Association of American Medical Colleges* 81, no. 2 (February 2006):176.

[14] Salimah H, Meghani and Vijay Rajput. "Perspective: The Need for Practice Socialization of International Medical Graduates--an Exemplar from Pain Medicine." *Academic Medicine: Journal of the Association of American Medical Colleges* 86, no. 5 (May 2011): 571.

[15] Manasi M Shah, Eleanor M. Summerhill, and Constantine A. Manthous. "Medical Professionalism in the New Millennium: Are There Intercultural Differences?" *Connecticut Medicine* 73, no. 5 (May 2009): 289.

of IMGs and have obvious practical value. What often goes unexamined in these studies is the use of "acculturation" as a normative goal to be achieved. Thus, the challenges IMGs face in adjusting to aspects of American practice culture are seen as obstacles to overcome rather than legitimate sources of critique of the system itself. One aspect of this dissertation will focus on these challenges, examining what they can say not just about IMGs, but about the system they are entering.

In order to represent these perspectives, I have drawn on two major sources of primary narratives from IMGs. The first chapter of this dissertation serves as an introduction to some of the alternative perspectives international clinicians have to offer on the US healthcare system---drawing on published narratives by clinicians who identify as IMGs. Abraham Verghese, an Ethiopian-born, Indian-trained Internist has written memoirs and fiction that engage with his US training and practice experiences as an IMG. Over the years, a small group of authors have contributed their own narratives to the personal essay sections of medical journals such as *JAMA* and the *Annals of Internal Medicine*. Later chapters of this dissertation draw on interviews I conducted with IMGs analyzing their perspectives of their own identities in medicine, the contrasts in training between the US and their home countries, and their choices to stay home, immigrate, or return. In framing the different analytical approaches of this dissertation with the more narrative based inquiries, I will connect, question, and contextualize how unrelated fields classify and approach these clinicians.

Recently, the growing field of Global Health has also engaged in a scholarly discussion about migrant clinicians, emphasizing not so much their utility and adaptation to their destination countries, but rather their loss to their countries of origin. Mostly

centered in rich-world Anglophonic nations, the global health movement, "has captured the imagination of a growing generation of health professionals who are motivated to make a difference across international boundaries."[16] The last two decades have witnessed "unprecedented growth in academic global health programs," at universities across the higher-income world.[17] Built on the foundation of 19th century tropical medicine, many of Global Health's "first-world" enthusiasts see their activities as the enactment of a charitable duty towards the needy, or as a way to promote justice and human rights through healthcare.[18] Until recently, proponents of this movement have shown little awareness of what Paul Farmer has described as "the irony [that] more and more trainees in affluent nations seek to dedicate at least part of their working lives to benefit the world's destitute sick, while the brain drain draws culturally and linguistically competent clinicians away from their homes."[19] Former head of the UK's NHS and global health proponent Nigel Crisp discusses this connection at length, noting that "the issue of health worker migration is one of the most emotive in healthcare."[20] Portrayals of brain drain tend to construct negative images of clinician-migrants as selfish and unpatriotic, abandoning the needy of their countries to seek high salaries and professional opportunities in the rich world. Nelson Mandela, for example, characterized the South African clinicians who left to work in Britain as "cowardly and unpatriotic citizens." Academics have employed words such as "looting," "poaching," and "stealing," in

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16 Vanessa B. Kerry, Thumbi Ndung'u, Rochelle P. Walensky, Patrick T. Lee, V. Frederick I. B. Kayanja, and David R. Bangsberg. "Managing the Demand for Global Health Education." *PLoS Med* 8, no. 11 (November 8, 2011): 1.

17 Ibid.

18 Claire L. Wendland, *A Heart for the Work: Journeys Through an African Medical School* (Chicago, IL: University of Chicago Press, 2010) 9-10.

19 Paul Farmer, quoted in Kayhan Parsi, "International Medical Graduates and Global Migration of Physicians: Fairness, Equity, and Justice," *Medscape Journal of Medicine* 10, no. 12 (2008): 284.

20 Nigel Crisp, *Turning the World Upside Down: The Search for Global Health in the 21st Century* (London, UK: CRC Press, 2010), 65.

reference to rich countries that benefit from the labor of medical migrants. The processes of health worker migration have been described as "fatal flows."[21] As Crisp argues, the issue of migration is a complex one, often motivated less by the desire for financial gain as by understandable desires to escape physically dangerous working environments, gain professional advancement, and open opportunities for family and children. This project engages with some of the questions this literature asks, using historical and qualitative analysis to explore why clinicians leave their countries of origin and why they often do not return home. Taken together these perspectives offer the idea that the impetus for migration is deeply engrained in global structures of power and historically anchored in the history of globalization of Western medical education.

Just as some fields are taking up particular lenses on clinicians who migrate, others have had surprisingly little to say on the subject. This project hopes to correct some of these oversights, bringing the insights and methods of history, qualitative analysis, and medical humanities scholarship to the entangled issues implicated in the stories of migrant clinicians in the United States. A survey of the bioethics literature, for example, only reveals a few articles that engage with the roles of IMGs. Lawyer and medical humanist/bioethicist Kayhan Parsi, writing for the online hub Medscape in 2009, for example, engages with the roles of IMGs in the US healthcare system and presents "brain drain" from poor nations to the US as a problem of justice. In presenting his perspective, however, he acknowledges that "there is a paucity of articles on this topic in the bioethics literature," something he finds "especially curious in light of the number of

[21] John Connell, *Migration and the Globalization of Health Care: The Health Worker Exodus?*. (Northampton, MA: Edward Elgar Pub, 2010),10.

interesting issues with regard to cultural competence as well as healthcare access and distributive justice raised by IMGs."[22]

Likewise, I found little evidence of specific engagement with this issue within the Medical Humanities. Though a broad field with many definitions, the Medical Humanities in the United States traces its origins to the 1960s and 70s when a group of medical educators and medical school chaplains gathered together to voice concerns about "depersonalization," "the centrality of molecular biology," and "the teaching of mechanistic medicine" that they saw in medical schools throughout the country.[23] Though people who practice the Medical Humanities may be interested in topics as diverse as the patient experience of healthcare, literature and visual expression, and the value structures of medical professionals, medical education is a common nexus of study and engagement for many scholars in the medical humanities community. Often involved in the teaching of medical students and residents, medical humanists such as Ronald Carson, Katherine Montgomery, Catherine Belling, and Arno Kumagai to name a few, draw extensively on experiences in medical education settings as a basis for their commentary and suggested interventions in the formation and education of clinicians. Scholars involved in the medical professionalism movement and those who study professional identity formation in medicine also situate their perspectives similarly. As Katherine Montgomery concedes, the interpretations she offers of medical epistemology in her monograph, *How Doctors Think*, are squarely situated in the resource-rich setting of American medicine, where

[22] Parsi."International Medical Graduates and Global Migration"284.

[23] Daniel M. Fox, "Who We Are: The Political Origins of the Medical Humanities," *Theoretical Medicine* 6, no. 3 (October 1985): 329.

learners encounter "the full panoply of Western medicine."[24] In focusing on diverse perspectives often missing from scientific medical education, teaching alternative ways of narrative and visual reasoning, emphasizing self-reflection, and fostering "incisive attention to specificity" in medical learners, medical humanities does indeed have a lot of offer to medical practitioners.[25] Work in this field, however, has been virtually limited to the Western, and especially, the American setting. Few studies exist on the intellectual, moral, and professional development of clinicians trained in non-Western settings. A few recent ethnographies, for example anthropologist Claire Wendland's *A Heart for the Work*, describing the experiences of students and residents at a Malawian medical school have made a few small but intriguing steps to correcting this deficit. As this dissertation argues, American medical education, and the American medical practice setting itself, is far from some sort of ideal or epitome of medical training and practice, but in many ways an outlier. American medicine and American medical training stands out, even among other wealthy countries for its peculiar orientation to resources. Through interviews with clinicians who trained and practiced both within and outside of the US this project elucidates this relationship.

The overwhelming focus of medical humanities scholarship and intervention on medical education in the setting of American medical schools may not only fail to reflect the experiences of clinicians across the globe, but of one quarter of American physicians. In paying attention to the perspectives of IMGs this project adds to more comprehensive understandings of the ways in which professional formation occurs among the range of

[24] Kathryn Montgomery, *How Doctors Think : Clinical Judgment and the Practice of Medicine* (Oxford, UK: Oxford University Press, 2005): 10.

[25] Catherine Belling, "Commentary: Sharper Instruments: On Defending the Humanities in Undergraduate Medical Education," *Academic Medicine: Journal of the Association of American Medical Colleges* 85, no. 6 (June 2010): 940.

American clinicians. Through this qualitative work I ask my participants to explore their formation as physicians, as well as what it means to be an American doctor.

As a field, the history of medicine has likewise treated the IMG issue as a peripheral curiosity. Foundational studies of medical practice and education in the 20th century, for example, Paul Starr's *The Social Transformation of American Medicine*, Kenneth Ludmerer's *Time to Heal*, David Rothman's *Strangers at the Bedside* and Rosemary Stevens' *American Medicine and the Public Interest* make very little mention of the role of foreign trained doctors. Although these works focus on how the medical profession, larger institutions such as hospitals and foundations, and the State have contributed to shaping the American healthcare and medical education systems, they do not account, except in passing, for the function played by this unique and sizable group of physicians. As I will argue in the historical chapters of this project, the role of IMGs has been critical, both in filling material gaps in physician-labor in the US healthcare safety net, but also in filling ideological gaps in philosophies of medical training and healthcare systems organization for decision makers in US healthcare.

In another national context, Simpson et. al., writing in the *Journal of the Royal Society of Medicine,* challenge their fellow clinicians and medical historians to "write migrants back in" to the history of Britain's National Health Service.[26] Thus, chapters two through four of this dissertation take up this challenge in the US context. Historians in other destination countries for healthcare workers, namely the UK and Canada, have begun to examine the role of international clinicians in their national healthcare systems. In the process these scholars have engaged with questions of national identity, physician

[26] Julian M. Simpson, Aneez Esmail, Virinder S Kalra, and Stephanie J Snow. "Writing Migrants Back into NHS History: Addressing a 'Collective Amnesia' and Its Policy Implications," *Journal of the Royal Society of Medicine* 103, no. 10 (October 2010): 392.

professional roles, legacies of race and colonial domination, and the critical role of history in shaping the realities of the present. As Simpson and colleagues remark, although multicultural clinicians have been critical to the very survival of the NHS since its early years, their roles have been systematically erased in triumphal histories of the NHS as a "typically British institution." Recent British work on migrant physicians has postulated that the British health care system itself could not have been realized in its current guise if not for the contributions of generations of foreign-trained doctors who filled the immense need for physicians in the UK after the establishment of the National Health Service.[27] These physicians filled junior posts, provided primary care in remote areas, and even founded entire specialties such as geriatrics.[28] The volume of their contributions, and the extent to which the system relied on them to be able to function has historically gotten little positive mention, with official histories of the NHS consistently downplaying the system's reliance on foreign-trained clinicians, and the British medical establishment contributing to subtle and not so subtle forms of discrimination against their overseas-trained colleagues.[29]

Wright et al., based at McMaster University in Toronto take up the historical perspectives on migrant physicians in Canada. Gathering oral histories, this group has highlighted the experiences of these clinicians as important to the broader history of medicine in Canada.[30] Wright et al. emphasize, however, that physician migration had not

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[27] Ibid.

[28] Parvati Raghuram, Joanna Bornat, and Leroi Henry. "Ethnic Clustering Among South Asian Geriatricians in the UK: An Oral History Study." *Diversity in Health and Care* 6, no. 4 (December 2009): 287–296.

[29] Emma L. Jones, and Stephanie J. Snow. *Against the Odds: Black and Minority Ethnic Clinicians and Manchester, 1948 to 2009*. Manchester NHS Primary Care Trust, 2010.

[30] David Wright, Sasha Mullally, and Mary Colleen Cordukes, "'Worse than Being Married': The Exodus of British Doctors from the National Health Service to Canada, C. 1955-75." *Journal of the History of Medicine and Allied Sciences* 65, no. 4 (October 2010): 546.

taken place in isolation from global social, economic, and ideological dynamics. Tying reactions to physician migration to the shift in the 1960s in the immigration policies of Western countries to a preference for highly skilled immigrants, this group's work recognizes the importance of examining this issue in the larger context of global migrations and historical processes.

Pravati Raghuram, writing from a primarily British perspective clues-in to this complexity. She critiques current discourses of "brain drain" as shaped by an ahistorical set of "spacial and temporal ontologies," that limit the discussion to a simplified balance between clinicians' right to migrate and their compatriots' right to healthcare. As she argues, however, the choice to migrate is rarely an abstract calculation by depersonalized healthcare workers maximizing some idealized notion of self-interest, but rather a complex set of decisions made in the context of historically delimited possibilities. As she argues, in some contexts, for example, in South Asia, becoming a medical worker already marks an individual as a transnational subject. In the fifth and sixth chapter of this dissertation, I, too, will broaden my historical lens, examining the migration of clinicians to the United States as one part of a complex history of the globalization of medical education. Just as the American medical system drew clinicians in from all over the world, it has also exported powerful ideas that have contributed to the globalization of medical education and exerted their own influence on the subjectivities and identities of physicians globally. This has played a major role in clinician migration.

METHODS

This project, anchored in historical analysis also draws on narrative analysis and on qualitative inquiry, with each perspective contributing to a multifaceted exploration of

a complex subject. The contribution of this dissertation emerges from the conceptual spaces between the ways these myriad scholarly disciplines have engaged or not engaged with the issue of migrant clinicians both in the US and the global context. Exploring the spaces between established scholarly discourses brings their insights into conversation while bringing into question some of their ingrained assumptions and values. Arthur Kleinman, whom I will draw on in framing several aspects of this project, claims that to be between disciplines is to be uncomfortable, to continually question your own positionality as well as well as commonly held assumptions and approaches of these disciplines themselves.[31] This inevitable interdisiplinarity intimates that perhaps the only place this project could find a home is within the intellectual lineage of the Medical Humanities. Although many definitions of the Medical Humanities exist, most of them share an insistence on the importance of bringing the interpretive skills, intellectual lineage, and relational focus of the humanities disciplines to the subjects of medicine and health broadly defined. The intellectual tradition in which I have been trained has focused on Renaissance Humanism as a historical and interpretive progenitor of the medical humanities. This historical grounding then becomes the foundation for an interdisciplinary perspective that incorporates approaches from fields as diverse as social science, history and literature to examine what is at stake in questions of health and healing.

Medical humanist Ronald Carson draws on the historical lineage of the re-emergence of rhetoric in the Renaissance to argue for its centrality in the intellectual approach of the medical humanities, highlighting Bowsma's pronouncement that

[31] Kleinman, 1.

"rhetoric, not philosophy gave us the humanities."[32] Political science scholar Gary Remer provides a more detailed historical study of rhetoric, emphasizes the concept of *Sermo*, a term originating from the ancient Roman tradition of discursive styles. As a style of argument, *Sermo*, unlike the better-known *Contentio*, presumes that interlocutors come to dialogue as equals, and no one person has the truth, but rather, each discussant has some aspect of it.[33] In *Sermo,* no one interlocutor wins the argument, but rather, truth emerges through dialogue.[34] *Sermo* becomes a central principle of both the subjectivity and the intellectual work of the medical humanist, reorienting his or her relationship to knowledge and intellectual inquiry. Knowing is contingent and multifactorial. Generalizable "facts" are not privileged over the "radical specificity" of particular experience and narratives.[35] Knowledge contains its own ambiguities and is subject to reconceptualization and revision through the contributions of different voices and perspectives.

In this, *Sermo* as an intellectual approach shares values with the methodology of interpretive phenomenology and grounded theory in qualitative research. According to nursing educator and theorist Patricia Benner, the qualitative researcher engages in the "dialogical process of learning to create, understand, and interpret texts."[36] When these texts are narratives of their research participants "the interpretive researcher creates a dialogue between practical concerns and lived experience through engaged reasoning and

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[32] Ronald A. Carson, "Engaged Humanities: Moral Work in the Precincts of Medicine." *Perspectives in Biology and Medicine* 50, no. 3 (2007): 330.

[33] Gary Remer, *Humanism and Rhetoric of Toleration* (University Park, PA: Pennsylvania State University Press, 1996). 26-27.

[34] Remer, *Humanism and the Rhetoric of Toleration*, 30-33.

[35] Belling, "Sharper Instruments," 940.

[36] Patricia Benner, *Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness* (Thousand Oaks, CA: SAGE Publications: 1994), 102.

imaginative dwelling in the immediacy of the participants' worlds."[37] This approach has a strong resonance with Carson's concept of the "moral imagination" as key to the transformative role of texts in the humanities.[38] Within this deep engagement the researcher takes part in a continual back and forth between "foreground and background," both privileging the narratives of his or her subjects while being "critically reflective" not only of their ideological, historical, and personal situatedness, but of the ways in which these factors impact the researcher him or herself.[39]

Like *Sermo,* interpretive research draws on a built-in ethical stance of "respect for voice and described experience."[40] This orientation demands epistemological humility on the part of the researcher, a willingness to change perspectives and orientations based on the narratives of their participants/interlocutors. Thus grounded theory and interpretive research differ markedly from the positivist perspective of medical and scientific research. The researcher does not start out with a question to be answered with data, but allows the "data" to revise and reformulate the question, and when necessary undermine it completely. Although the researcher "establishes boundaries and lines of inquiry…these must be held tentatively and allowed to be challenged, altered, extended, and transformed by what is learned in the field." Thus the researcher's questions should be "altered, shaped and reexamined by dialogue with the actual text."[41]

Within the scope of my project, I worked to maintain this ethical stance of *sermo* and interpretive research both in engagement with interviews that I collected from IMGs

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[37] Benner, *Interpretive* Phenomenology, 99.

[38] Carson, Ronald A. "Educating the Moral Imagination," in *Practicing the Medical Humanities: Engaging Physicians and Patients*, ed. Ronald A. Carson, Chester R. Burns, and Thomas R. Cole (Hagerstown, Md: University Publishing Group, 2003), 25.

[39] Benner, *Interpretive Phenomenology,* 99-100.

[40] Benner, *Interpretive Phenomenology,* 101.

[41] Benner, *Interpretive Phenomenology* 105.

and with regard to other textual sources such as primary sources and written narrative I included in the first half of the dissertation. Thus, I did not go into this dissertation with a pre-set argument, with a point I needed to prove or a policy recommendation I needed to enforce. Rather my motivation was a strong sense that this larger story and in particular the stories of individual clinicians and migrants that make it up are deserving of attention. This is not a project focused only on bringing awareness to the rich issues this inquiry unearths and entangles, though this is also important, but one that calls for careful narratively and historically attuned attention to these stories, their contexts, and their broader implications. However, my background as an interdisciplinary scholar both abetted and complicated approaching part of this project as a grounded theory inquiry. More familiar with the interpretive lenses of literature and medicine and of history, I found this approach to qualitative work drew on the same broad skillsets of careful reading and textual engagement. The concept of *ad fontes*, the Renaissance humanist call to return to the sources took on new meaning as I redefined sources from static written narratives to the evolving narratives of lived experience in the form of interviews with subjects who have first-hand knowledge of what it means to be an international physician. My progress in this work has been marked by self-reflection bordering on self-doubt. At several stages of this dissertation I have wondered if I was really the right scholar or the right person to do this work. In particular, the process of recruiting subjects for the oral histories proved challenging. Perhaps this can be connected back to my status anxiety as a scholar, accepting the idea that I had the legitimacy to ask people to take the time to contribute to my work. Another aspect, however, was the incongruence among my own disciplinary perspectives. As someone with a background in the clinical and

quantitative research questions of medicine, the qualitative, grounded theory approach causes a certain amount of discomfort, possibly enhanced by the attitudes of my research participants, who as physicians themselves, were perhaps somewhat bemused by my approach to this topic.

POSITIONALITY

As Benner notes, identifying a researcher's relationship to his or her work, as well as exploring the biases he or she may bring to the project as a whole and to individual encounters with research participants is a crucial part of the ethical stance of interpretive research. Ultimately an interdisciplinary, qualitative project such as mine collects and tells stories. In the process of interpretation, it also tells stories in the context of other stories. From this perspective, it would be difficult to ignore my own background and positionality as the story that consciously or unconsciously has defined the content and approach to this work. This is a dissertation about migration, professional identity, medical education, and the real and possible roles of International physicians in American medicine. These are topics and ideas that I have come to through my own experiences and that I cannot help but have a personal stake in.

Although I myself am in the process of completing my medical education in an American medical school, I have been keenly aware of the experience of International physicians since long before I decided to pursue medicine myself. Although it is not always obvious from the way I present myself, I, too, am an immigrant and a child of immigrants. Though this is something I experienced as a very young child, immigration has had an indelible impact on my life, my worldview, and my sense of place in the

various identities I take part in. Growing up in immigrant-heavy neighborhoods of Los Angeles, I have always been fascinated by the migration stories that surrounded me--as a "millennial" coming of age in a global city, traditional "Ellis Island" narratives that highlighted American exceptionalism as a nation of immigrants as well as the image of the immigrant as the white, usually male ethnic experiencing an inexorable process of assimilation and advancement never quite rang true. Many of the migration stories I was surrounded by, of family members, of friends, and parents of friends, spoke to a greater complexity and hinted at the ways race, gender, family ties, cultural affiliation, class, and professional identity are entangled in the processes of migration, as well as the in the ways immigrants constructed their own identities.

As one of my research mentors often puts it, "research is me-search" and these experiences have been crucial in my desire to become an MD/PhD, my path to medical humanities and history, and my specific research directions. In my family, immigration and professional identity have been deeply entwined, and medicine as a career has been bound to identity, sense of place in the community, family relationships, and perceptions of self-worth. From the time when we first arrived in Los Angeles from what was then the Soviet Union in the late 1980s until the early 2000s when she finished residency, I have watched my mother struggle to re-establish her career as a physician. The challenges she faced included language, finances, and of course the responsibility of raising two young children while navigating the seemingly arcane, punitive and arbitrary process of American medical credentialing for graduates of foreign medical schools. For my mother, however, medicine seems to truly be a part of who she is and her passion for her career was partly formative of my own desire to enter the field. During the years my

mom was preparing for exams, my Grandmother, who herself had been a physician in the USSR, was the main caregiver for my brother and me. For her and for my grandfather, also a physician, medicine was entangled with identity in other, complex ways. As Jewish doctors in a society and a profession marked by open anti-Semitic tensions, their identities as physicians were a source of security as well as danger. Being a part of the medical profession was partly a way of negotiating their insider/outsider status in Soviet society. Among my family members and their friends and acquaintances who immigrated in the years leading up to the fall of the USSR, my mother was not the only physician, but she was one of the few who was able to re-establish her career. The Russian immigrant community I grew up in was rife with stories of men and women who used to be doctors, working as medical assistants, lab techs, and shopkeepers. Although many adjusted to this professional shift, for others the psychological consequences of perceived occupational downgrading were very significant.

As I entered American medicine as a medical student myself, and began to study it from my emerging perspective as a medical humanist, I found that the stories of immigrant physicians were more or less missing from the broad consciousness of physicians and those who study them. This did not mean that these physicians were themselves missing, however. For particular reasons I describe later, many of the resident and attending physicians I worked with on the wards were immigrants or visitors, often from South Asia and the Middle East. Likewise, many of my medical school classmates have been first and second generation Americans. It became clear to me that my family members' stories as physicians and as immigrants were very particular, an example of the many different ways International physicians see themselves and inscribe meanings on

working in US medicine. It was these reflections that became the genesis of this project. As someone with a background in history, both as an undergraduate and as a major emphasis in my graduate work, this type of analysis naturally formed the backbone of my work, and became the starting point for the question: *Why are the stories and experiences of IMGs missing from the consciousness of American medicine and the disciplines that study it?*

In the words of politically-active paleontologist Stephen Jay Gould, "we have a much better chance of accomplishing something significant when we…work in areas of deepest personal meaning."[42] In my preemptive survey of dissertations in the medical humanities, I have found, subjectively, of course, that some of the most powerful and creative work in the field has had its genesis in the author's personal experience with suffering, and with the experiences of being and becoming patients and clinicians. These individuals have written the dissertation only he or she could have written. Although Gould acknowledges that this approach increases the danger of bias, he also argues that prejudice and the danger of unexamined assumptions are present in any scholarly work, no matter how seemingly objective. Like Gould and Benner, I reinforce my commitment to "vigilance," and to acknowledging as many of my assumptions and biases as I am aware of coming into this project.

For this reason, I have taken the time and page space to recount my personal history. Just as my positionality toward the subject matter is of interest to my readers, however, it became apparent in the course of our conversations that the clinicians I interviewed were themselves fairly keen on establishing my positionality, often asking

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[42] Stephen Jay Gould, *The Mismeasure of Man (Revised & Expanded)*(New York, NY: W. W. Norton & Company: 2006), 37.

about my background and about the source of my interest in the subject of international medical graduates. These discussions were generative in and of themselves, as it became clear that my interlocutors imposed their own meanings on our conversations. In the course of this project I spoke with clinicians of different ages, statuses, and specialties. Several, for example, approached the interaction as faculty-mentors, a reasonable approach given that I could well have been their student and on some occasions, have been. Others, especially those who were approximately a generation older, identified me with their children, particularly if they themselves had children pursing a medical education. Thus they emphasized aspects of immigration, "assimilation" and professional success, and how they contrasted between first and second generation immigrants as well as between classes and categories of immigrants. A Chinese-born pathologist I spoke with, for example, reflected on questions of identity and immigration in comparison to his perception of my background. In his words:

> I still think there are some barriers. Maybe we have different opinions, for you as a white coming from the Russian Soviet Union you don't uh … because for me, people tell me I'm different. They say you, you are Chinese … even my daughter who was born here, they will ask her, *where do you come from?* Because they still think you look different…[43]

Other interviewees, perhaps closer to me in age, who were residents and early career physicians, identified me with the US medical education system and with their American colleagues. One of my interviewees, for example, describing her perspective on the future of IMGs in the US healthcare system emphasized, "*you* don't have enough doctors."[44] To some of them I represented the US graduate perspective, not just on IMGs, but on a variety of issues. Thus an awareness of my positionality toward the subject matter of this

[43] Wei Z. interview with author, January 2015.

[44] Laila A. interview with author, November, 2014.

study was crucial, as was my growing awareness of how that positionality was seen by others. As I set about crafting the qualitative aspects of this dissertation, I became increasingly aware of the value of context, specificity, and positionality to my analysis.

NOTES ON QUALITATIVE WORK

In the last few chapters of this project I will draw heavily on material from interviews that I have conducted with physicians who have experienced American medicine as International Medical Graduates. All of these interviews were conducted within the past year and my sample is best described as one of opportunity—consisting of physicians with whom I could make a connection and who had the time and made the effort to speak with me. Although I began this study with the idea of doing a systematized survey of IMGs who have completed residency in the Houston-Galveston area and selecting interviewees based on age/immigration cohorts, I found this approach to be bulky and impractical for my purposes. Instead I employed a "snowball" methodology, reaching out to potential interviewees through my own colleagues and mentors. With a personal connection as starting point, I found it easier to build a level of trust with participants as well as lay claim to a share of any physician's most valuable resource: time. In turn, these interviewees often suggested friends, colleagues, and mentors of their own with whom I could speak. In the end, many of my participants were, unsurprisingly, somehow connected to UTMB, and were largely clustered in Texas, primarily the Houston area. However, these physicians' personal journeys had taken them across the US and beyond. Geographically, my interviewees were dispersed from El Paso to Southern Canada. Most of my interviewees, for example, were current or former UTMB residents and faculty, several, however, were not, and entered my study because

they were colleagues, parents, friends, or collaborators of my institutional interviewees and other contacts. Many of my interviews were conducted by phone, though I made the efforts to speak to my participants in person when this was possible.

I asked each of my participants for a one hour interview, many however, spoke to me more than once or were willing to extend our conversations, sometimes for several hours at a stretch. I came upon these individuals at varied stages of their personal and professional lives and sometimes at critical junctures in their careers—faced with choices about staying in the US, returning home, pursing fellowships, deciding between academics and private practice. I am grateful to them for narrating these often very personal struggles to me. When I sought IRB approval for this project, physicians were certainly not classified as a vulnerable population. As the interviews progressed, however, I came to appreciate that by sharing personal stories, histories, and perspectives many of these individuals were in fact placing a certain amount of trust in me. This is particularly true given the often competitive, stratified environment of medicine and the local nature of politics at a moderately sized medical center in a small city. All have been given a copy of their interview transcripts and been given a chance to make corrections or omit sections. Throughout these next few chapters I have tried to treat their stories with respect and be cognizant of my participants' vulnerabilities. On a nuts and bolts level, this has meant not using real names, although I stay true to the genders, professional specialties, and geographic origins of my interlocutors, I use pseudonyms to identify them in this text. On a less concrete level, I have tried to be judicious; drawing on a multiplicity of voices, so no one voice is easily identifiable to the casual reader.

Berkeley Anthropologist Aihwa Ong borrows the term "commuter fieldwork," to describe her study of Southeast Asian refugees in the San Francisco Bay area.[45] Like any qualitative study in her field, she describes, her qualitative work was shaped as much by the constraints and opportunities of the researcher as by the material itself. Like Ong, I chose to center my research around my geographic base, and this has certainly flavored the data I collected and the types of stories that I can tell. As some of the introductory chapters to this dissertation have intimated however, studies about IMGs, as well as published narratives that describe this group's experience are relatively sparse, and those that exist are heavily skewed toward the American Northeast. Partly this is because the urban centers of the American Northeast do indeed foster large numbers of IMGs as well as other professional immigrants. However, IMGs, who have been an integral part of the US healthcare system, have also had distinct impacts across geographic and social spaces, from elite medical institutions, to urban hospitals to small Midwestern towns. Thus "commuter fieldwork" that anchors my qualitative observations in the Houston-Galveston area may indeed contribute to a more varied, richer perspective on the IMG experience and impact in the US. Unlike the Northeast, with a history of controversy and dependency of IMGs since the 1940s, for example, Texas, and UTMB specifically, saw IMGs became a significant presence in later decades. By 2008, the AMA IMG section listed Texas sixth among the "top twenty" destination states for IMGs.[46] According to internal data on house officer backgrounds, UTMB, for example, saw relatively few IMGs until the 1980s. Since that time, however, their numbers have shown an upward

[45] Aihwa Ong. *Buddha Is Hiding: Refugees, Citizenship, the New America* (Berkeley and Los Angeles: University of California Press: 2003) xvi.

[46] American Medical Association. "IMGs by State." Accessed July 26, 2015. http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates/imgs-in-united-states/imgs-state.page?

trend from 1 or 2 a year in the early 1980s to peaks of approximately 94 and 100 entering residents and fellows in 1994 and 2010 respectively.[47]

The numbers and methods within this study are not well suited to a full quantitative comparison of countries of origin, specialty of training, or other parameters of IMGs training at UTMB or in the greater Houston area with national trends. However, my unrepresentative sample of clinicians does offer tantalizing hints about regional variations in IMG roles and suggests directions of future research. One notable example (discussed in more detail in chapters 7 and 8) of the value of regional flavor, for example, comes from a number of physicians from South and Central America I spoke with over the course of my interviews. Although I did not specifically seek to speak to this group of physicians, they have been strongly represented in my sample, whether by random chance or a result of the networks that I plugged in to solicit my research participants. Several have described a specific interest in seeking out training opportunities in Texas and have either pursued work in border cities and towns or otherwise described professional work among Hispanic populations within and outside the United States. Several have also described how their perspectives and opportunities have been broadened and constrained by their backgrounds, their interests, and national and international needs for Spanish-speaking clinicians. The roles and the very presence of this contingent of "border physicians," become more visible in a qualitative study located in a particular place and time.

As many of my interviewees, a good number of them experienced researchers, have pointed out to me, the data I gather about IMGs at UTMB is likely to be "biased" by

[47] Data from UTMB Office of Graduate Medical Education.

some major events particular to the institution's recent history. IMGs, they explained to me, are likely to be overrepresented as a consequence of the devastating impact Hurricane Ike had on the institution in September of 2008. The result, they explained, was to discourage US-educated medical students from applying to residencies, creating opportunities for IMGs. As the institution recovers from the impacts of the storm, however, these numbers are likely to drop. Asked about the proportion of IMGs in their resident cohorts, recent graduates from primary care fields have described large proportions of IMGs. One was quick to add, "I think it's because they're just more open to interviewing International Medical Graduates and that's only because of the storm. I think pre-Ike they didn't take as many IMGs, because it suddenly became unattractive."[48] Others commented on the rapid decline of IMGs in their programs in recent years, "so let me see, so that class that I interviewed when I was a third year, they would be second years now. They're all American grads except for two people…American grads or American born. There may be one IMG, but before that at about 50/50 … I think a part of that was a UTMB issue of after the storm, people didn't want to come here, so they got people that wanted to come."[49]

What for a certain type of research would perhaps be interpreted as bias, was however, a bonanza for my study, eliciting rich discussions about perceptions of status difference between IMGs and US grads. These conversations, in turn, led to discussions about how graduate medical education in the US assessed the value of particular physicians, and how that reinforced certain roles for IMGs. This is perhaps one of the

[48] Laila A. interview with author, November 2014.

[49] Mateo N. interview with author, July 2014.

great strengths of qualitative work, drawing conceptual richness from the particular and contingent rather than the representative and generalizable.

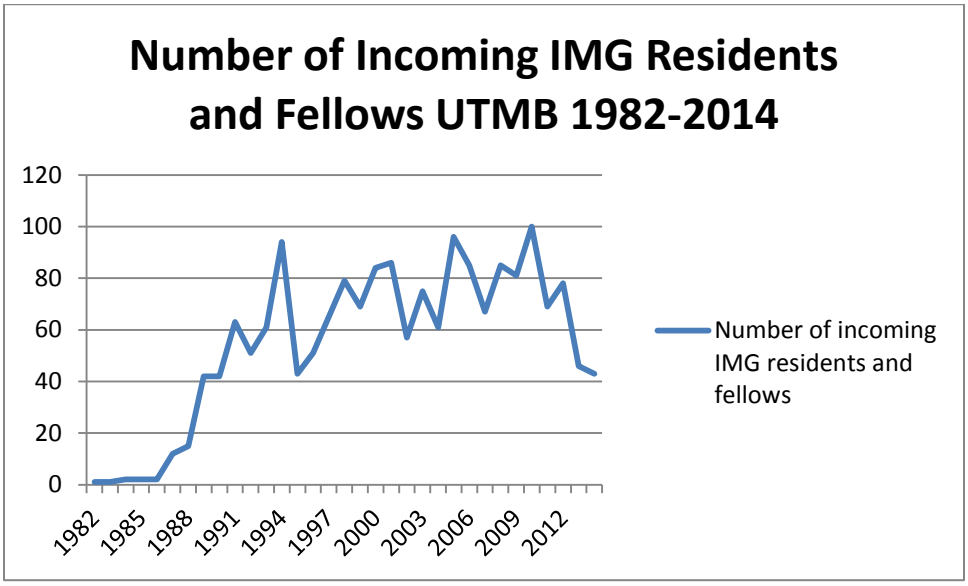

Figure 1: Incoming IMG Residents and Fellows UTMB 1982-2014

As one participant replied to a question about stereotypes, "IMGs are a mixed bag of nuts, I guess any stereotype is untrue because this is such a heterogeneous population of people…"[50] Even with a sample ten times the size of my cohort of interviewees, I do not believe I could have claimed that it was somehow representative of the variety of rich and complex life stories that bring physicians to live and train in the United States (or for that matter, anywhere). However, a careful reading of each interview as well as the act of putting these stories in conversation with each other can provide valuable insights not only specifically into the experiences of IMGs, but also more broadly on the experiences of being a doctor, of migrating, and of defining oneself as a citizen in a globalizing word. Overall, I spoke with thirteen physicians who varied in age from their mid-20s to their late 60s. On their professional trajectories, this put them as current residents, fellows,

[50] Adnan R. interview with author, July 2014.

private practitioners, and full faculty. Four were completing national interest waivers at the time I spoke with them, working in health professional shortage areas in exchange for a path to immigrant status. The great majority were working and training in primary care specialties, with nine in either Family or Internal Medicine, two in Pathology, one in OB/GYN, and one surgeon. National and ethnic origins varied as well, with two physicians each from India, Pakistan, and Mexico, as well as individuals from Egypt, El Salvador, Canada, Botswana, China, Kenya and Jordan. Even physicians from the same countries, however, sometimes described very different circumstances and personal and professional trajectories.

Name*	Gender	Country of origin	Specialty	Decade of Arrival in US
Karthik R.	M	India	FM	2000s
Mateo N.	M	Mexico	FM	2000s
Juan P.	M	Mexico	FM	2000s
Adnan R.	M	Canada/Hungary	FM	2000s
Laila A.	F	Pakistan	FM	2000s
Arjay N.	M	India	IM	1960s
Wei Z.	M	China	Path	1980s
Majid F.	M	Egypt	Path	1970s
Sofia S.	F	El Salvador	OB/Gyn	2000s
Ester L.	F	Kenya/Uganda	IM	2000s
Farris T.	M	Jordan	IM	2000s
David T.	M	Botswana**	IM	2000s
Amir H.	M	Pakistan	Surgery	1960s

*All names are pseudonyms selected by the author
**this individual trained in Australia but is pursuing an advanced degree in the US

Table 1: Summary of Interviewee Demographics

The diversity in the stories I have collected harkens back to Arthur Kleinman's explorations of margins and textures. Each of these narratives claims its own particular perspectives on the experiences of medical training, on the experience of working in two

or more healthcare systems and on the experience of migration, whether the individual becomes an immigrant or remains a visitor. In each of these stories, my interlocutors describe their various identities, as physicians, as researchers, as family members, as children, parents, siblings, as members of particular social classes, as citizens or aspirational citizens of particular states. Like good post-modern subjects, many of my interlocutors assimilate their many identities, sometimes handily, sometimes with difficulty. It is the friction between identities and the ways in which they express them that marks their stories as ones written at the margins. These stories deserve attention not only in their own right, but in the insights they can provide from their often unique perspectives. Likewise, this confluence of identities changes the textures of experience. The journey to becoming a physician in the United States is completely different experience, not only between IMGs and USMGs, but as this collection of 13 stories demonstrates, within these two very broad categories as well. The next chapter will attempt to sketch some of these textures of experience, describing the literary and reflective depictions of IMGs and identifying some of the narratives in which their experiences have been placed. After tracing the historical trajectory of this project I return to these personal stories and their insights in the final two chapters of this dissertation.

Chapter 1: Margins and Textures: Narratives by and About Migrant Physicians

As Jack Coulehan and Anne Hunsaker Hawkins have put it, physician writing is "a growth industry."[51] The public seems to have an insatiable appetite for physician memoirs, unveiling the secrets of medical training and the daily dramas of medical practice. Well-known physician-writers, though they do seem to reflect the ethnic diversity of medicine, overwhelmingly tend to be American-trained physicians from elite academic institutions. Conspicuously sparse are views from the one quarter of American physicians who have come to the United States as immigrants or working visitors, collectively known as international medical graduates (IMGs). Abraham Verghese, an Ethiopian-born internist of Indian decent is a notable exception, however, publishing non-fiction memoirs *In My Own Country*, and *The Tennis Player*, as well as the fictional work, *Cutting for Stone*, all of which explicitly deal with the experience of immigrant physicians in the United States.[52] Generally, narratives by and about the experiences of internationally trained physicians are tucked away in a variety of places. Some of them can be found in special article and personal narrative sections of major medical journals, for example, *JAMA*'s "A piece of my mind" column, the *Annals of Internal Medicine'*s "On being a Doctor," and *Academic Medicine's* "Learning and Teaching Moments" sections. Additionally, some of the narratives I draw on in this chapter are journalistic, usually human interest pieces from major newspapers such as the *Washington Post* and

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[51] Jack Coulehan and Anne Hunsaker Hawkins. "Keeping Faith: Ethics and the Physician-Writer," *Annals of Internal Medicine* 139, no. 4 (August 19, 2003): 307–11. 307.

[52] Technically Oliver Sacks, British-educated neurologist and author of *Awakenings, An Anthropologist on Mars, Musicophilia*, and *The Man Who Mistook His Wife for a Hat*, would be considered an IMG physician writer. However, this identity does not figure very prominently in his writings, whether for personal reasons, or because as a British physician coming to the US in the 1950s he would not necessarily have been treated as a member of this group.

the *New York Times*. Finally, some narratives are eclectic or incidental, garnered from documentary films and news reports. Sometimes it is only through these occasional narrative exposures that US-trained physicians and the American public become aware of medicine's unspoken class system, one that often couples the county's most vulnerable patient groups with International Medical Graduates, themselves sometimes positioned as second-class citizens in the hierarchy of the medical profession. Although this dissertation focuses on the roles of foreign-educated and immigrant physicians in the US context, this more-literary focused chapter will meander somewhat across national boundaries as a nod to the complexities of entities such as migration and care. The United States is not alone among rich nations in importing large numbers of physicians, and some of the narratives I will draw on in this discussion are set in places such as Australia and the UK. I justify their inclusion here because they are published in American medical journals or have become a part of the US cultural discussion about IMGs in other ways.

Cultural discourses about IMGs center on their relationship to the needy much more heavily than do discourses about other groups of doctors. This chapter will examine narratives that are (and are not) available about IMGs. Narratives by individuals who are a part of this group often embody Arthur Kleinman's concept of the view from the margin. Kleinman, a physician-anthropologist, sees himself as writing at the margins of both of his disciplines, and it is this "eccentric perspective," outside the mainstream that enables him "to find a space of critical engagement."[53] Likewise, his engagement with "the margin and the marginal," those experiencing "illness, poverty, and other forms of human misery," animates the alterity of his perspectives.[54] I am appropriating some of

[53] Kleinman, *Writing at the Margin,* 2-3.
[54] Kleinman, *Writing at the Margin,* 3.

Kleinman's complex definitions of views from the margins to the narratives I will be analyzing in this chapter. In this I am not claiming that IMGs are somehow by definition more critically or socially aware than their American (or Western)-educated counterparts, however, I do see stories by and about them as stories about the margins of the medical profession. Likewise, in as much as IMG stories deal with how this group relate to vulnerable groups of patients, these narratives offer a perspective rooted at the margins of societies, whether in these physicians' destinations or countries of origin. The very sparsity of these narratives and their comparative absence from certain ways of talking about physicians both within and outside of medicine are a testament to their marginality. Rarely, for example, are the roles of IMGs roles invoked in discussions about some of the key initiatives to assess and reform medicine and medical training, for example, questions of health disparities, "cultural competence," ethics and professionalism, and professional identity formation. In the spirit of Kleinman's musings, I pay special attention to the various liminalities of these physicians—simultaneously in positions of power and vulnerability, in some ways insiders to the culture of medicine, and in other ways, outsiders to the cultures that they enter, and sometimes those to which they return. Narratives by and about international physicians present a different perspective on the experience of being a physician in the US, and reveal some of the gaping systemic deficiencies this group has been called upon to fill. The narratives examined in this chapter will prefigure later discussions that place some of these issues in a US and international historical context. In this chapter I will explore some of the alternative perspectives that narratives of internationally-trained physicians have to offer on

structural issues and the healthcare safety net, on questions of engagement between physicians and patients, and on issues of migration, identity and citizenship.

IMG NARRATIVES AND THE HEALTHCARE "SAFETY NET"

In her provocatively titled 1992, book *Mama Might Be Better off Dead*, journalist Laurie Kaye Abraham follows the health care struggles of one family living just above the poverty line in Chicago's blighted North Lawndale neighborhood in the late 1980s. Following the Barnes family through their healthcare encounters and spending time with them at home, Abraham demonstrates how poverty, race, and the US healthcare "nonsystem" intertwine in a demoralizing and often deadly cycle.[55]

Abraham connects this one family's struggle to the public policies that affect the besieged hospitals and health centers where they seek care. Interviewing the physicians, social workers, and hospital and social program administrators that come into contact with the family, she discovers that these individuals too are affected by the fragmentation of the system they work in, displaying attitudes that range, in Abraham's interpretation, from genuine concern to complacency. Interestingly, many of the motley crew of physicians and heath para-professionals that encounter the Barnes family are immigrants from all over the world. Dr. Hector Marino, the family's occasional primary care doctor opened his "storefront" private practice in North Lawndale after arriving from the Philippines in the 1970s. Dr. Boris Gurevich and Dr. Leonid Shvartsman the internist and the psychiatrist who take care of the Barnes family matriarch who is repeatedly

[55] Laurie Kaye Abraham, *Mama Might Be Better Off Dead: The Failure of Health Care in Urban America* (Chicago, IL: University of Chicago Press, 1994), 2.

hospitalized for gangrene after years of undertreated diabetes are both Russian-Jewish immigrants. After her hospitalization, a physical therapist, originally from Pakistan, Talha Ahmed Shamsi visits her at home. Drs. Amarit Singh and Yogi Ahluwaliia who also figure in the story as attendings and residents at Mt. Sinai hospital in Lawndale came to the US to practice medicine from India and Pakistan. Even Dr. Joyce Rosenfeld, an American-born physician in Mt. Sinai's overburdened ER comes with a surprising international flavor, having finished medical school in Guadalajara, Mexico.

Abraham does not spend much time reflecting on what connects the roles of these clinicians to the Barnes family. In any case, most of these clinicians are mentioned briefly and are not portrayed as particularly helpful or sympathetic. These doctors, she assumes, are opportunists, working with the poor because their training and skills, presumably inferior, do not allow them to practice elsewhere.[56] Through several discussions among characters in his 2009 novel, *Cutting for Stone*, Abraham Verghese also connects the roles of international medical graduates to the American urban poor, but offers an alternative, more complicated perspective.

When the main character, Marion Stone, arrives from Ethiopia in 1980 to train in surgery in at Our Lady of Perpetual Succor, a fictional hospital somewhere in the Bronx, he is bewildered to find that all of his fellow residents are like him, recent arrivals from abroad. At the entrance to the dormitories he is greeted by a flier advertising an upcoming cricket viewing party as well as "…a faint drone on the second floor landing of 'Suprabhatam' sung by M.S. Subblakshmi and the sound of a bell being rung, as

[56] Abraham, *Mama*, 4.

someone in some other room did their *puja*. "[57] Marion is equally surprised by the patients he sees as he is by the doctors he works with:

> After a week in the hospital I felt I had left America for another country. My world was a land of fluorescent lights where day and night were the same, and where more than half the citizens spoke Spanish. When they spoke English it wasn't what I expected in the land of George Washington and Abraham Lincoln. The bloodlines from the *Mayflower* hadn't trickled down to this zip code.[58]

Marion also reflects on the contrast between the America of popular culture, and the America he experienced on the drive from the airport with the neighborhood of the hospital. Just behind the house-staff dormitories is "a housing project named Friendship by the city authorities twenty years ago. It was now called Battleship by one and all. At night we heard the pop of handguns from Battleship and saw comet streaks, messages from earth to sky."[59] After a patient comments that "but for you-all, there wouldn't be any doctors here," Marion asks a more senior resident, "….where are the other American patients? Where are the other American doctors?" His senior, a Jamaican, corrects him, "you mean, where are the white patients? Where are the white doctors, mon?"[60] As his senior explains using a salt and pepper shaker as props, their establishment, like many in New Jersey, the outer boroughs of New York City, and other large cities such as Chicago and Detroit is:

> … an Ellis Island Hospital. Such hospitals are always placed where the poor live. The neighborhood is dangerous. Typically such hospitals are not part of a medical school…now take this saltshaker, That is a Mayflower hospital, a flagship hospital…Every American medical student dreams of an internship in a Mayflower hospital. Their worst nightmare is coming to an Ellis Island hospital…so every year Our Lady and all the Ellis Island Hospitals look for

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[57] Abraham Verghese, *Cutting for Stone*. (New York, NY: Vintage Books, 2010), 473.
[58] Ibid, 476.
[59] Ibid, 487.
[60] Ibid, 489-490.

> foreign interns. You are part of hundreds who come as part of this annual migration that keeps these hospitals going.[61]

For the government, he explains, "it's a win-win, the hospital gets patients cared for…and Medicaid delivers healthcare to the poor." Even when the "Mayflower Hospitals" take care of the poor, they explain, "It's honorable, like being in the Peace Corps, you know?" But, he remarks bitterly, the work they do at hospitals like Our Lady is "shameful, the work of untouchables." Thus the interns of Our Lady refer to the teams of doctors who arrive from academic medical centers for organ harvests as "the masters of medicine, the sahibs."[62]

This section of Verghese's novel has a somewhat picaresque, satirical tone reminiscent of Samuel Shem's classic novel of residency training *The House of God*, yet non-fiction accounts and memoirs often take up the same themes as Marion's disgruntled seniors. Together these narratives describe a largely unofficial class system that American medical trainees and patients in well-resourced areas may at most be vaguely aware of, as well as reveal uncomfortable truths of the sheer scale of social abandonment within inner cities and the depth of these areas' un-met medical needs. For Virender Sethi, an Indian-educated physician, quoted in a 2000 *Washington Post* article, these factors shaped his residency experience in Jersey City: "In my first year here, I saw a kid die from a drug overdose on the hospital's front steps… In India, my feeling was that the US would be like heaven, which Jersey City certainly was not."[63] A 1998 account in the same newspaper describes Ben Taub, Houston's largest public hospital, also at one time partly staffed by international physicians, as "a good hospital, but the one that draws

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[61] Ibid, 490-491.

[62] Ibid, 478-479.

[63] Michael A. Fletcher, "Cultures Converge in Public Hospitals; Social Fabric of American Health Care Can Be a Challenge for Foreign Doctors." *Washington Post*, February 21, 2000.

some of the sickest patients, the street people, with nowhere else to go," "In the emergency rooms… indigent patients are lined up, gurneys pressed together, the dinged-out and the damaged, with no insurance, waiting their turns and soiling their sheets."[64] The context of this description is equally interesting, appearing in an article titled, "By the Sweat Of Their Brows; Immigrants' Hard Jobs Re-shape the Economy," which profiles the work of a Guatemalan day laborer, a Mexican window washer, a Vietnamese nail salon owner, and an Indian doctor, all in the "gateway city" of Houston, Texas—grouping IMGs with other immigrants who find opportunity in the jobs Americans cannot or will not do.[65]

In his memoir *In My Own* Country, published in 1994, Abraham Verghese describes the experiences that inspired these aspects of his novel. The "signs of urban rot in Newark, Elizabeth, Jersey City, Trenton, and New York," motivating "The (insured) middle class" to flee to the "glass-fronted hospitals…[that] popped up on the freeway like Scandinavian furniture franchises." Leaving,

> the once grand county hospitals [to slide] inexorably, like the cities themselves into critical states…Their patients had become the uninsured and indigent whose problems revolved around drug addiction and trauma….an inevitable accompaniment to this scene of a city hospital under siege was the sight of foreign physicians. The names of these doctors like Shrivastava, Patel, Khan, Iqbal, Hussein, Venkateswara, Menon, had no resemblance to those of the patients being served or the physicians who supervised them.

In a 2012 article in the *Journal of Medical Education*, an American graduate from a relatively elite program demands that residency directors confront "the elephant in the room," the tiered systems of training for American and International medical graduates.

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[64] William Booth, "By the Sweat of Their Brows, A New Economy; Immigrants' Hard Jobs Re-Shape the Economy." *Washington Post*, July 13, 1998.

[65] Booth, *Sweat of Their Brows*.

He begins his perspective piece by describing the response he got from friends and colleagues when he chose to join the faculty at a majority- IMG internal medicine residency, "at the time, some admonished me that I would be throwing away my career on 'missionary work.'"[66] As Verghese remarks in his memoir, often in these IMG-heavy programs, call nights were frequent, sleep hard to come by and instructional time minimal. "The work was grueling, the conditions appalling—but only by American standards."[67] Many international graduates came already accustomed to coping in even more under-resourced situations. As Oncologist Alok Khorana, who came to the US form India in the mid-1990s, recalled of his intern year in an Indian hospital, "thirty to forty patients were housed in two large rooms… as a first year resident I was the person on first call for these patients all day, every night, 365 days a year."[68] This tiered training system, widely known to exist, but largely unspoken, could create situations that make International graduates vulnerable. In his memoir, for example, Verghese describes using the ethnic information networks of IMGs across the country to avoid being trapped in one of the "infamous pyramid residencies," who accepted IMGs for their labor in the first year and then refused to renew their contracts to allow them to complete training.[69]

As the residents of Our Lady glibly remark, foreign physicians have been crucial in caring not just for urban, but for rural Americans, finishing residency and moving to places "like Toejam, Texas or Armpit, Alaska. The kinds of places American doctors

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[66] Constantine A. Manthous, "Confronting the Elephant in the Room: Can We Transcend Medical Graduate Stereotypes?" *Journal of Graduate Medical Education* 4, no. 3 (September 2012): 290–92. 291.

[67] Abraham Verghese, *My Own Country: A Doctor's Story* (New York, NY: Vintage Books, 1994), 18.

[68] Alok A. Khorana, "Disorientation." *Health Affairs (Project Hope)* 27, no. 4 (August 2008): 1154–59. 1155.

[69] Verghese, *My Own Country*, 17.

won't go and practice."[70] Reporter Jenna Johnson, in a 2007 human interest piece in the *Washington Post*, illustrates this phenomenon in her description of the plight of St. Mary's county in rural Southern Maryland. The region's county hospital "used decades-old equipment, struggled to make payroll and had no full-time specialists."[71] And despite desperate needs, remained a place where "no doctor wanted to settle," until Vinod and Ila Shah, an Indian-educated husband and wife team just out of residencies in Washington D.C. founded a practice. Within a decade, they had recruited over a dozen physicians of various specialties to work alongside them, many of them family members and fellow immigrants. The head of the local hospital described them as "miracle workers," the "answer to my prayers." Johnson portrays the Shahs as typical of the "foreign-born doctors who have been the unlikely medical backbone of rural America," providing healthcare for 90,000 of the county's 110,000 residents. A 2002 PBS special entitled "Foreign Country Doctors," further illustrates this theme, profiling the physicians of Eutaw, Alabama who "say a lot about how the face and name of the country doctor has changed in America."[72] When Sandrall Hullett, the town's only physician was nearing retirement, she turned to recruiting international medical graduates just completing US residencies. A federal program, which allows physicians on a visitor visas to convert to immigrant status by practicing in shortage areas, helped bring Adnan Seljuki, Mohammad Siddique, Salahuddin Farooui, and Lourdes Ada to town. As the commentator points out, these physicians, are "Muslims in a mostly Christian town,

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[70] Verghese, *Cutting for Stone*, 492.

[71] Jenna Johnson,"Born in India, Transforming Rural Md.; Extended Family of Medical Specialists Helps St. Mary's Thrive." *Washington Post*, December 7, 2007.

[72] "Foreign Country Doctors." *PBS NewsHour*. Accessed May 1, 2015. http://www.pbs.org/newshour/bb/health-jan-june02-doctors_6-18/.

foreign born in the town where most people's families go back generations."[73] Yet despite concerns that these physicians would leave after satisfying their visa requirement, several stayed beyond the term. In his memoir, Verghese, who chose to begin his practice in a small academic medical center in rural Johnson City, Tennessee, recalls the dynamics of small town medical life:

> The effect of having so many foreign doctors in one area was at times comical. I had once tried to reach Dr. Patel, a cardiologist to see a tough old lady in the ER…I called his wife and his wife told me he was at "Urology Patel's" House, and when I called there I learned he and "Pulmonology Patel" had gone to "Gastroenterology Patel's" house. Gastroenterology Patel's teenage daughter, a first-generation Indian-American, told me in a perfect Appalachian accent that she "reckoned they're over at the Mehtas' playing rummy…[74]

With the exception of personal memoirs by Khorana and Verghese, the journalistic narratives that describe the roles of foreign physicians in the US all share an overall tone of surprise. Their readers, they seem to anticipate, will not have heard of the expansive roles of foreign physicians in American healthcare, or of the scale of the social problems that they face. Fitzhugh Mullan's 2002 compilation of oral histories, *Big Doctoring in America,* introduces perhaps a more common way internationally trained physicians figure in narratives pertaining to American medicine: as an invisible or absent group. The aim of Mullan's book, collected from a series of essays published in *JAMA*, is to valorize health professionals in primary care, using life stories of individuals who have made an impact with their work to discuss the challenges and the potentials of the field. The clinicians he describes are presented as role models, for example, Neil Calman, "urban warrior," and "flag waving family physician," who practices in the Bronx, Connie Adler, a specialist in rural medicine who has served Framington, Maine for 25 years, and

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[73] Ibid.

[74] Verghese, *My Own Country*, 23.

Sam Ho, "idealist, innovator, and entrepreneur," who has forged a career as a high level health-systems administrator.[75] *Big Doctoring in America* is an unabashedly ideological work, aiming to use the work lives of these primary care heroes to "throw down the gauntlet" for the future of generalist medicine.[76] Of the fifteen providers profiled, however, not a single one of these previously unsung heroes of primary care are International physicians. Given that IMGs, especially at that time, made up close to 50% of American primary care physicians, this omission is worth exploring.[77] Many of the clinicians profiled in the book are celebrated for their work with underserved populations, the same groups that many IMGs routinely work with. What are the implications of the exclusion of this group from the heroes of primary care? Perhaps for the editors of the collection, the difference is that the physicians they profile chose to serve these populations even though they did not have to. Yet this omission echoes the glib interns of Our Lady of Perpetual Succor and their remarks about how caring for the poor becomes labeled as "Peace Corps" or "untouchable" work, depending on who does it.

Together these portrayals in journalism, memoir, and fiction sketch a relationship between Internationally- trained physicians and America's most vulnerable and needy patients. At least from the perspective of these snapshots, many IMGs end up as safety-net providers, often taking residencies and opening practices in places and institutions their native-trained colleagues do not favor, working in urban public hospitals, rural clinics, prisons and mental institutions. The narratives above also demonstrate the range

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[75] Fitzhugh Mullan, *Big Doctoring in America: Profiles in Primary Care* (Berkeley and Los Angeles: University of California Press, 2004). 29, 38, 138.

[76] Ibid, 220.

[77] "International Medical Graduates. Immigration Law and Policy and the U.S. Physician Workforce. Council on Graduate Medical Education Resource Paper. A COGME Panel Discussion (Washington, DC, March 12, 1996).," January 1997.

of interpretations of this group's roles in the US healthcare system. Abraham's view of IMGs as primarily self-interested opportunists contrasts with Johnson's portrayal of IMGs as heroic figures, overcoming obstacles and providing much needed care to underserved in rural areas. Mullan's view pointedly does not acknowledge either role, envisioning an ideal of the revival of primary care in which this group has no place. Interestingly, Arthur Kleinman's chapter in *The Illness Narratives,* titled "The Healers: Varieties of Experience in Doctoring," also a collection of physicians' life stories makes a similar omission, despite including a perspective from a traditional Chinese healer, none of the biomedical physicians he profiles is an immigrant or international physician.[78] Somehow, immigrant physicians, an inescapable presence in certain healthcare settings in the US since the 1940s, are missing from the imaginary of reflective physicians and academics who study medicine and the professional lives of doctors.[79] As Simons and colleagues argue in an article on the role of migrants in the British National Health Service (NHS), the UK, like the United States, has had an overall culture of marginalizing the contributions of international doctors and nurses in its triumphal narratives about health and healthcare.[80] When you exclude a group from history, they ask, what does it mean for the ability to discuss that group's future roles? Reviewing the roles migrants have played in the NHS, taking on a large part of the burden of care for the elderly, the mentally ill, and the working class, "could lead us to

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[78] Arthur Kleinman, *The Illness Narratives: Suffering, Healing, And The Human Condition*. (New York, NY: Basic Books, 1988) 209-226.

[79] See next chapters for a history of roles that IMGs have played in the US.

[80] Julian M Simpson, Aneez Esmail, Virinder S Kalra, and Stephanie J Snow. "Writing Migrants Back into NHS History: Addressing a 'Collective Amnesia' and Its Policy Implications." *Journal of the Royal Society of Medicine* 103, no. 10 (October 2010): 392–96. 392.

reflect on what importance British society attaches to these groups."[81] Simon's remarks could well be applied in the US case. What is at stake in not discussing the roles of IMGs in the United States? Like in the United Kingdom, many international physicians work at the margins of the healthcare system, where its fraying fabric meets the rough edges of profound social problems and inequalities. To talk about this group of physicians means talking about why they are needed. Thus, as one of Verghese's interlocutors, a fellow IMG describes, "we are an embarrassment to this society, a *prob-lem*."[82] As I will discuss in more detail in the next chapter, organized medicine has had a history of claiming a public service role in rationally regulating the medical profession. Acknowledging the scale and history of physician migration to the US brings this as well as many other structural aspects of the US healthcare system and doctors' roles in it into question.

FOREIGNNESS AND THE DOCTOR-PATIENT RELATIONSHIP IN NARRATIVES

As we have seen above, narratives by and about international medical graduates working in the US healthcare system can offer a different, sometimes disquieting perspective on structural issues writ large in American medicine. These narratives' "eccentric" perspectives have value on a more intimate, but no less important scale, exploring aspects within the doctor-patient relationship that look different when the role of foreignness in the encounter changes. In the discourse of medical education's widespread emphasis on "cultural competence" in the curriculum, it is the patient that is

81 Simpson et al, "Writing Migrants Back," 394.

82 Abraham Verghese, "The Cowpath to America." *The New Yorker*, June 23, 1997. 79.

expected to be somehow foreign. The cultural competency curriculum aims to teach physicians how to encounter patients that are culturally unfamiliar to them, either members of a minority group or recent immigrants with language and cultural barriers to understanding the healthcare system.[83] A few articles, published in journals targeting medical specialties with large numbers of IMG trainees such as Family Medicine and Psychiatry address some questions that come up when the physician is the cultural other.[84] Likewise, stories of initial faux-pax on the part of International physicians when first encountering some element of American culture abound. Alok Khorana, now a Rochester, New York, oncologist, recalls embarrassing himself in front of a nurse his first night on call in an American hospital, not knowing that Tylenol was the American trade name for acetaminophen. Another typical story appears in a journalistic account about IMGs at Kings County hospital in Brooklyn, quoting Sudha Rao, now a pediatric HIV specialist, who recalls one of her first American patient encounters: "I didn't know people could get pregnant with no husband…when I learned differently I got scared, I didn't know this went on."[85]

Residency directors and others interested in IMG education have discussed the above issue under the rubric of acculturation: that IMG residents need better support in adapting to the practical and social aspects of American culture. Over the years, some

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[83] Delese Wear, Arno K. Kumagai, Joseph Varley, and Joseph Zarconi. "Cultural Competency 2.0: Exploring the Concept of 'Difference' in Engagement with the Other," *Academic Medicine: Journal of the Association of American Medical Colleges* 87, no. 6 (June 2012): 752–58. 752

[84] Salimah H Meghani, and Vijay Rajput. "Perspective: The Need for Practice Socialization of International Medical Graduates--an Exemplar from Pain Medicine." *Academic Medicine: Journal of the Association of American Medical Colleges* 86, no. 5 (May 2011): 571–74.

[85] Michael A. Fletcher, "Cultures Converge in Public Hospitals."

have designed curricula and orientation programs for this purpose.[86] Practically speaking, these programs have a lot of value, but the discourse about them can reduce the negotiation of the gulf between doctor, patient, system, and society to an annoyance soon to be overcome as IMGs "acculturate" into the American system. IMG narratives, however, attest to the fact that although many often adapt quickly and gain the skills they need, their origins, whether subtly or dramatically, continue to affect their positionality toward the patients they work with and the frames they learn to think in. The nuances of this subjective experience for doctor and patient may elude quantitative measures but are captured in narrative and memoir.

A 2004 piece published in the "On Being a Doctor" section of the *Annals of Internal Medicine* by Australian physician Ranjana Shrivastava, describes some of the everyday challenges of this process of adjustment. In the piece she describes her mentoring relationship with an unnamed resident, a recent immigrant to Australia from an unspecified conflict-torn country. Awoken by this resident to assist with a teenaged asthmatic he claims is about to stop breathing, the narrator finds the patient "surrounded by a coterie of giggling teenagers, all looking remarkably fresh for the time of the night," instructs her to stop hyperventilating, and expresses her annoyance with the resident for the false alarm. She is later mollified when he sheepishly explains, "the patient said she didn't want to see a doctor with an accent and then started acting very sick, I was scared."[87] Later, coaching him to prepare for exams, she corrects him when he instructs a mock diabetic patient to prevent "crackles in your toys." "Cracks in your toes," she has

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[86] Myrle Croasdale, "Classes Teach New IMGs American Style Medicine." *Amednews.com*, December 11, 2006.

[87] Ranjana Srivastava, "A Foreign Concept." *Annals of Internal Medicine* 140, no. 12 (June 15, 2004): 1057–58. 1057.

him repeat. She is surprised, however, at his adeptness at diagnosing neurological lesions, and for the first time, he explains that he was a neurosurgeon in his home country. As she learns his life story, she comes to view his struggles with respect rather than annoyance. After operating on a young girl hurt in a terrorist attack he had decided to flee his county in order to ensure his son grew up someplace safe. Bringing his family out took time and "meanwhile he lives in the hospital quarters, the tenuous phone lines are his only link to the people left behind."[88]

Shrivastava's story highlights the ways in which perceptions of foreignness distance the unnamed subject of her narrative from the patients and physicians around him. These perceptions create insecurities that pepper IMG narratives. Alok Khorana, describing an experience caring for a man in the final stages of lung cancer, for example, wonders if his status as a "young trainee with a foreign accent," diminishes his patient's confidence in his recommendations to switch to palliative care.[89] Abraham Verghese, in his memoirs *In My Own Country* and *The Tennis Partner* also remains aware of his identity as an immigrant and as an IMG even after years of success in the United States. The effects of this identity are complex and sometimes alienating, yet at other times allow for unexpected understandings in his relationships with patients. Even after years of "acculturation," and reasonable success, "a full professor at the age of thirty-seven, as high up in the academic ranks of a lesser medical school as I had ambition to reach," he still feels a "largely unjustified and well-concealed paranoia," a sense of being an impostor in medicine.[90] Such insecurities are certainly not unusual among medical

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[88] Shrivastava, *Foreign Concept*, 1058.

[89] Alok Khorana, *At the End of the* Day, in Mullan, Fitzhugh, Ellen Ficklen, and Kyna Rubin. *Narrative Matters: The Power of the Personal Essay in Health Policy* (Baltimore, MD: JHU Press 2006): 238.

[90] Abraham Verghese, *The Tennis Partner* (New York, NY: HarperCollins, 1999), 33.

professionals, but for him "this sentiment had its roots in…being a foreign medical graduate in a two-tiered system where foreign graduates were treated as second rate."[91]

Throughout his professional experiences in different parts of the United States he remains hyperaware of how it feels to be a foreigner, a "brown-skinned man," and an IMG in these various settings.[92] As an intern in Johnson City, Tennessee, he recalls a surprising level of acceptance, relishing the occasions when patients and colleagues introduce him as a "'Good ole boy'…the highest compliment they could pay each other. It was the highest compliment they could pay me."[93] To his surprise, however, "the first time I experienced racism, felt it as a palpable presence in my daily life, was in Boston," working at an elite medical center.[94] Later, as a faculty member in El Paso, recalling a typical medical team consisting of South Asian, Middle Eastern, and South American residents and Anglo medical students treating a Hispanic patient, he remarks "foreignness—my own and that of others seemed less noticeable…living on the border."[95]

Verghese credits his identity as a foreigner with setting him on his professional path. With a strong recommendation from his residency director and an emphasis on his scientific publications to "erase my foreignness" he is able to secure a prestigious fellowship in infectious disease, a less popular, less remunerative specialty, which on the eve of the AIDS crisis seemed intellectually dull to Americans who had their choice of programs.[96] Returning to Johnson City as an infectious disease specialist just as the

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91 Verghese, *Tennis Partner*, 33.
92 Verghese, *In My Own Country*, 23.
93 Verghese, *My Own Country*, 41-42.
94 Ibid., 23.
95 Verghese, *Tennis Partner*, 22.
96 Verghese, *My Own Country*, 26.

advent of AIDS made the field relevant again, he becomes the primary physician and "surrogate activist" for a growing group few knew existed, the HIV patients of rural America, many of them part of a local gay community the town "pretended… did not exist."[97] [98] For both Verghese and his HIV patients the recognition of the other's outsider status deeply impacted the physician-patient relationship. Verghese describes an initial ambivalence, concerned that something he did or said would, "reveal my ingrained societal homophobia, my lack of sophistication, my foreignness," some of these feelings, however, stem from his own sense of being an outsider, wondering if they possessed his same honed ability to, "see through your white coat and your politeness and lay bare your prejudice."[99] Eventually however he describes a certain feeling of kinship between his "chameleon-like instincts of a lifelong expatriate," and the closeted lives many gay men led, allowing him to "glimps[e] the faces behind the masks:"[100] [101]

> I became…keen to compare their stories with mine. There was an obvious parallel: society considered them alien and much of their life was spent faking conformity; in my case my green card labeled me a "resident alien." New immigrants expend a great deal of energy trying to fit in: learning the language, losing the accent, picking up the rituals of Monday Night Football and Happy Hour. Gay men, in order to avoid conflict also became experts at blending in, camouflaging themselves, but at great cost to their spirit.[102]

Verghese feels that patients too sensed this commonality, as the son of a patient tells him, his late father was thankful for "in part your compassion, but also your foreignness—as if you were a messenger from another world."[103] In a small, traditional town, Verghese

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[97] Ibid., 276.
[98] Ibid., 70.
[99] Ibid., 58.
[100] Ibid., 171.
[101] Ibid., 65.
[102] Ibid., 58.
[103] Ibid., 384.

reflects, perhaps many found it easier to be frank with him about their lifestyles than with a "Caucasian face that could just as well have belonged to a preacher, a judge, or some other archetypal authority figure in the community." "More than once," he reflects, "I had the sense that a patient was opening up to me…*because* of my foreignness."[104] Many of his patients had in fact had negative experiences with previous providers who happened to be local, with one patient recalling being told his lifestyle was "ungodly" by a new doctor.[105] For Verghese, however, even this sense of solidarity among outsiders, however, creates ambivalence between pride and insecurity. He wonders whether perhaps some patients are so open because they feel that "as a foreigner I had no *right* to pass judgement on them."[106] As time goes on Verghese feels his identity has become entangled with the AIDS patients he treats, and as their growing numbers and the ambiguity towards them strains the outward tolerance of the healthcare workers and community members of Johnson City, he felt increasing stress. The community's rejection of his patients became a rejection of him. Enveloped in a world marked by the stigma and death of the early years of AIDS, he felt "alienated …from other physicians, from friends, even from my wife. By God if what I was doing was noble, why did it feel like something…something shameful?"[107]

Several expressions of "naked, ignorant, shameful prejudice" from health professionals he thought he knew bring these doubts to a head. The most jarring is his phone conversation with a pharmacist who revealed a patient's HIV status to his dentist. Far from being apologetic about violating the patient's confidentiality, the pharmacist

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[104] Ibid., 116-117.
[105] Ibid., 117.
[106] Ibid.,117.
[107] Ibid., 168.

insists that his loyalty was to the dentist, hissing, "I'll just take care of *my* doctors."[108] The conversation "shattered the illusion that I was so much a part of the town, so well-integrated, that I even looked like the townsfolk." "The words 'foreign doctor' rang in my ears, even though he had not said them."[109]

As Verghese's story indicates, to say that foreign physicians are somehow by nature more tolerant of difference is an oversimplification. *My Own Country* contains several descriptions of foreign graduates who share their American-born colleagues' fear and prejudice toward AIDS patients or that demonstrate narrow-mindedness in other ways. Much of what Verghese has to offer his AIDS patients, particularly in the years before treatments became available consists of compassion, empathy, education, and activism, traits and skills which are not specific to a particular "type" of physician. Although the experience is sometimes painful, his own struggles with identity and acceptance lead him to acknowledge and explore those of his patients. Verghese explains how his role as "lifelong expatriate," an immigrant, and member of a rarely acknowledged underclass in his profession, gives him access to a view from the margins, a perspective that encompasses aspects invisible from the center. Through his narrative he tells a story about the early AIDS epidemic in rural America that would have been invisible to academic researchers at elite institutions and even to AIDS activists mostly centered in New York and San Francisco. Through his memoirs he is also able to tell the story of a new wave of immigrants and the roles they take on in American society. Verghese's experience is not so much a validation of his particular type of marginality as

[108] Ibid., 307.
[109] Ibid., 308.

an example of how marginal clinicians can find ways of relating to patients that may be of unexpected value.

Alok Khorana, in a 2005 piece published in the Narrative Matters section of *Health Affairs* also uses his view from the margins to highlight the people and ideas that aren't visible from the center. His piece, entitled "concordance" describes his role as the "sometime oncologist" of the 82 year old patriarch of a large and supportive family. Diagnosed with metastatic rectal cancer and treated with surgery, the patient has several infections and other medical complications that prevent starting chemotherapy. Over this period, however, the doctor has gotten to know him and his family, describing him as an "amateur musician, Mets fan, preacher, foster parent, horror movie buff." Eventually his cancer progresses further and the care team come to feel that hospice is his best option. Believing that they have done everything right so far by having this conversation months in advance, they call a family meeting. Although the family "listened, asked questions, discussed issues back and forth, agreed in principle," they asked for more time." [110] As days go by however, the family struggles with making a decision, agreeing to transfer him to hospice care but hesitating over the DNR order. At this point, the narrator wonders if there is something about him that keeps him from gaining the family's trust. Citing the trending literature on race concordance and how it appears to improve qualitative and quantitative aspects of the clinician-patient encounter, he wonders if this may be why he isn't reaching the family. In this situation, however, the literature on race concordance between physicians and patients, including an Institute of Medicine Report from 2002 entitled *Unequal Treatment*, is of little use. Although the patient is black, Khorana

[110] Alok Khorana, "Concordance" in Mullan, Fitzhugh, Ellen Ficklen, and Kyna Rubin. *Narrative Matters: The Power of the Personal Essay in Health Policy*. (Baltimore, MD: JHU Press, 2006) 204.

explains, "I am neither black nor white. I am brown but I am not Hispanic. I am also not alone."[111] Although literature about racial disparities and physician-patient relationships focuses overwhelmingly on the interactions of white doctors and black patients, it gives no guidance for the 25% of US physicians who are IMGs, mainly of Asian and Hispanic origin. He wonders if the family perceives him as making decisions based on their race, worse yet, he wonders if he is, asking "had I internalized the healthcare system's prejudices? Did they think of me as if I were, well, white?"

Furthermore, he remarks, the metrics of race concordance do not accurately portray the structures within medicine that assort doctors and patients: "A black patient is far more likely to encounter a non-white IMG physician than a black physician. In certain Veterans Affairs and county hospitals, one is more likely to encounter a non-white IMG physician than even a white physician."[112] Ironically, this thrust in medical thinking, which aims explicitly at noticing and addressing issues of race in medicine, "treat[s] as invisible" an entire group of physicians whose majority of patient interactions are by definition "race-discordant," and who are very likely to encounter patients who suffer from health disparities.[113] In the end, the family's concerns turn out to be more about sorting out their own values than about any mistrust of their physicians, and an experienced palliative care nurse practitioner helps them work through their hesitation. For IMGs and perhaps for 1st generation American-educated physicians the way academic medicine groups frame questions of race concordance, much like they often frame issues of cultural competence, can be further alienating. Including this fairly large group complicates already difficult conversations about race in medicine and so it seems,

[111] Ibid., 205.
[112] Ibid., 206.
[113] Ibid., 206.

many scholars chose to ignore them altogether. Khorana argues that increasing American minority participation in medicine is essential. Physician-patient concordance, however, is a means to the end of alleviating health disparities. Perhaps another means to improving doctor-patient relationships, discordant or otherwise, is through the views and adaptations of clinicians who learn to work at the margins. Perhaps there is also value in physicians being able to offer patients a more expansive kind of concordance, being able to recognize experiences of liminality, of otherness, of feeling out of place that may be inherent to so many aspects of experience, including the very fact of being a patient.

NARRATIVES OF MEDICAL MIGRATION AND VIEWS FROM THE GLOBAL MARGINS

Narratives about physicians migrating across the globe elicit rich questions of identity and citizenship. Read together, these stories bespeak a different kind of marginality, like other immigrants, these individuals and families find themselves between cultures, negotiating, sometimes joyfully, sometimes uncomfortably, between old, new, and in-between identities. Likewise, these narratives bring forward ways that their subjects find themselves negotiating the margins of their identities as physicians, members of families, and patriots and community members. In the process these narratives can reveal larger structures of marginality, revealing how global inequalities determine what it means to be a doctor in different places.

Sandhya Suri's deeply personal 2005 documentary film *I for India* explores 40 years of her family's experience of immigration from India to the United Kingdom. Suri's father Yash, the major focus of the film, graduates from medical school in India

and brings his young family with him to Manchester in 1965. In his own words, believing in the "myth of return," he only plans to spend a few years abroad, just long enough to gain a specialization he could not get in India.[114] Missing his family back home, he purchases two super 8 cameras and audio recorders so the families can exchange audio and video missives, creating a remarkable archive of images and words his documentarian daughter draws upon. Early tapes are filled with optimism for return, and feature lighthearted images of the Suris socializing with British nurses, and of their daughters playing in the snow. The years drag on however, Yash is offered a senior consultant position, an almost unheard –of opportunity in the UK for a foreign doctor at the time, and he decides to stay longer. The couple's second daughter is born, then their third. The family buys a house.

Suri intermixes footage from her family's films with documentaries and news reports of a similar vintage. Images from the late 70s became increasingly xenophobic, showing National Front rallies calling for "repatriation" of "colored" immigrants and comments by Margret Thatcher about preserving British culture. Likewise, Yash does not always feel accepted in his new role, explaining on one tape "I'm sick and tired of people not calling me by my family name, They can't manage to pronounce Suri…some idiot will call me Fury, some Dury… Sometimes they say "Hey Paki."[115] Despite this tension, the videos betray subtle ways the family is acquiring the *habitus* of their new society: the tapes they make are increasingly in English rather than Hindi, images of the daughters at birthday parties surrounded by blond children become more frequent. When Yash's mother dies he begins to feel increasing tension between his roles and identities,

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114 *I for India*, directed by Sandhya Suri (2005; London, UK: ICA, 2007), DVD.

115 Ibid.

lamenting "I wasn't able to lessen her suffering, alleviate her pain, like a good son, a medic son."[116] Soon afterwards the family returns to India. They move in with family while Yash opens a practice. As one of his daughters recalls, "he's always dreamt of coming back and being the great doctor and doing charitable works as well as having a thriving clinic, quite often when I came it was empty. Having seen Dad in the big hospital in Darlington where he's a man of standing …" was a stark contrast to seeing him as just one of many returnee doctors, competing for business in a disorganized, corrupt system.[117] The readjustment to life in India is no easier for Yash's wife or for his daughters, who are in many ways British. After nine months they chose to return, a decision that years later they still hope was the right one. Yash and his family find themselves in a space between identities. For Yash, in the end his identity as a doctor, a member of his family, and an Indian patriot, once intertwined, become conflicted. His response is to craft a new way of being a patriot: Suri ends the film with her father's voice saying "do not underestimate YPS with regards to his patriotism…his loyalty… no matter that he did not succeed in his own county…to resettle… the love for my soil hasn't diminished, I'm a true Indian."[118]

The Suri family story gives viewers a glimpse of the complex threads of identity, duty and circumstances intertwined in the lives of increasing numbers of migrating professionals. The challenges and ambitions of leaving the home country often pale in comparison to the struggles and anxieties over returning (or not). These narratives of conflict over migration and the possibilities of return by migrant physicians can be a source of insight into global structures of marginality in healthcare. Nigerian physician

[116] Ibid.
[117] Ibid.
[118] Ibid.

Sunny F. Kuku, in a 2000 piece published on the American College of Physicians website describes the challenge of returning home after training in the United Kingdom and the United States. “During my stay in Chicago the whole world opened for me… job offers from all nooks and crannies came to me,” while “all my attempts at securing a suitable position at home did not meet with any measure of success.”[119] He finally returns home with no prospects, experiencing a period of unemployment before getting a fortuitous offer. Nephrologist Abeera Mansur, describes the incredulous reactions she and her husband received from friends and colleagues, American and Pakistani alike, when they announced their determination to return to Pakistan after ten years in the United States. The challenges they encounter explain why, she remarks, “there is no shortage of jobs, but these jobs don't even pay for your children's school tuition.”[120] Both she and her husband work additional hours in a private practice in order to make ends meet in addition to working in public hospitals and fulfilling their faculty duties at a medical school. The greatest challenges, however, are resources, “one is surprised everyday by yet another something that isn't how it should be. You learn to become a nurse, a technician, a social worker and a pharmacist in addition to being a physician.”[121] The lack of infrastructure, healthcare and otherwise, becomes glaringly obvious, and “one is faced with this poverty at the individual patient level, when people have to sell even their clothes in order to provide medical care to their loved ones.”[122]

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[119] Sonny F. Kuku. “International Medical Graduates - Return to Home Country: A Thirty Year Perspective From Nigeria.” Accessed May 7, 2015. https://www.acponline.org/about_acp/international/graduates/practicing_in_us/kuku.htm.

[120] Abeera Mansur. “International Medical Graduates - Return to Home Country: Thoughts of an IMG Mother.” Accessed May 7, 2015. https://www.acponline.org/about_acp/international/graduates/practicing_in_us/mansur.htm.

[121] Mansur, “Return to Home Country.”

[122] Mansur, “Return to Home Country.”

Impotence in the face of these structural issues is a source of personal and professional distress for the large numbers of doctors who migrate and the trickle who return. Verghese for example, begins a 1997 reflective piece in the *New Yorker* with a description of a rabies ward in the Indian public hospital he worked in as a medical student. The patients are seen as hopeless cases, and provided with comfort care. The realities of his experiences, however, are contradicted by the authoritative statements of his American medical textbooks, which state that with state of the art intensive care and ventilator support, rabies patients could survive. By his intern year, his initial excitement about medicine had been "replaced by a sense of impotence," as patient needs continually "outstripped resources."[123] He sought to leave an environment where "doctors were as numerous as fleas," but had no resources to treat the desperate medical conditions they encountered.[124] As a frustrated colleague told a skeptical American consular officer, he wanted to come to America to become "…a wonderful doctor and practice *real* medicine," in a "decent ten-story hospital where the lifts are actually working. I want to pass my…exams through my own merit, not through pull or bribes."[125] For him staying in India is a conflict of identity, preventing him from becoming a doctor who practices "real medicine." Ranjana Shrivastava, in a 1997 personal reflective piece published in *The Lancet*, describes her experience as an Indian-born Australian medical student spending a rotation with Dr. Jha, an expatriate physician who if one of the few who does return to care for his needy countrymen in Bihar province. She finds the experience deeply moving, but returns home conflicted. Dr. Jha's capacity for work is seemingly superhuman, with workdays sometimes lasting from 4am to 9pm, and although the care

[123] Verghese, *The Cowpath to America*, 71.
[124] Ibid, 77.
[125] Ibid, 74.

he gives is hurried and may not be state-of-the art, it is compassionate and relieves suffering. Shrivastava asks herself is she would be capable of doing that kind of work, if she is selfish for not doing it, "am I my brothers' keeper?" she asks.[126]

In Kleinman's explorations of margins and marginality, he is drawn to the implications of the *Oxford English Dictionary's* definition of the word, as a border that "differs in texture from the main body."[127] In stories by and about migrant clinicians the "textures," of experiences such as medical training, connections with patients, and constructing identities as physicians and citizens can be tangibly different. These narratives, told from the margin between insider and outsider, can often tell the stories that are not visible or do not matter from the perspective of the center. In the US context, IMG narratives often provide perspectives from the shameful edges of the healthcare system where vulnerable clinicians treat even more vulnerable patients. These narratives are also interlaced with rhetorical images, how these physicians portray themselves, and how they are interpreted by others. Some of these stories see these clinicians as immigrants trying to negotiate complex personal and professional identities in a complex, unequal, globalizing world. Other portrayals can be more essentializing. Third person narratives about international physicians can present them as heroes coming to serve the needy, or opportunists leaving behind the needy of their own countries to profit off the less fortunate in other places, or often simply as invisible labor. These extremes of the rhetorical image of IMGs are far from neutral, and have real effects on policies affecting these physicians and their patients. The next chapter will take a historical perspective on these images, examining where they come from and what is at stake in them. These

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[126] Srivastava, Ranjana. "An Indian Dilemma." *Lancet* 350, no. 9073 (July 26, 1997): 286.

[127] Kleinman, *Writings at The Margin*, 1.

physicians work at rich intersections of concepts, cultures, and ideas and their experiences cry out for more stories. Later chapters will connect some of the themes broached in this brief discussion of narratives with the qualitative research aspects of this project.

Chapter 2: Strangers at the Bedside: *Alien*, *Foreign*, and *International* Physicians in the US Healthcare System, Beginnings to 1945

INTRODUCTION

The two bold headlines of the December 1979 editorial page of *Modern Healthcare*, a journal aimed at hospital executives, present a rather ironic juxtaposition. The main article, entitled "Soaring Bad Debts and Illegal Aliens," bemoans the lack of federal response to the "swelling band of illegal aliens," overwhelming small private hospital emergency rooms. [128] It is accompanied by a cartoon depicting private hospitals as a man perched on top of a sinking rowboat being pulled under by illegal aliens while, Uncle Sam, depicted as a lifeguard, naps in his beach chair. The second article, shorter and lower down the page proclaims, "We Need FMG's," and addresses another group of immigrants, without whom "urban hospitals will have an increasingly difficult time recruiting house officers and filling positions on their medical staffs."[129] Due to congressional legislation passed in 1976, "they are being shut out of this country to the dismay of many inner city and rural hospitals." The unintended message of these two articles, likely on the same page only incidentally, is that one group of immigrants is desperately needed in order to take care of another. The FMG article goes on to quip that although "the public and Congress were convinced that FMGs aren't as well trained as US graduates," lately, "the AMA has begun to spread the word that FMGs aren't so bad after all."[130]

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128 "Soaring Bad Debts and Illegal Aliens,"*Modern Healthcare* 9, no. 12 (December 1979): 3.

129 "We Need FMGs." *Modern Healthcare* 9, no. 12 (December 1979): 3.

130 "We need FMGs," 3.

As described in the previous chapter, the rhetorical role of IMGs in discourses about American healthcare has fluctuated over time, with periods of conspicuous invisibility punctuated by bursts of intense anxiety. Although foreign-educated and immigrant physicians have been a constant presence in the US healthcare system throughout the 20th and 21st centuries, their roles have only become a major point of public and professional contention on a few historically defined occasions. The next three chapters will examine some of these points of conflict through the lens of the 20th century development of American Medicine and the US healthcare system. This history reveals how in many ways medical migrants and discourses about them have masked major structural issues in US healthcare. In the following chapters I will focus on three contentious periods for IMGs in the US: the years before and during WW2, the 1970s, and the late 1980s and early 1990s. I will also comment on ongoing trends in the second decade of the 21st century.

These developments did not play out in a vacuum and the debate over medical migrants or as they have been termed over time, "alien," "foreign," or "international" physicians has also reflected larger American cultural anxieties about immigration and the ways in which it has transformed American society throughout the 20th and 21st centuries. The articles above describe two antithetical images of immigrants, deployed at the same time and place to describe two different groups. The "illegal aliens" of the first article are the "bad" migrants, perhaps worthy of pity as "downtrodden brethren," but ultimately unsympathetic and unassimilable, demanding resources and offering nothing in return.[131] "FMGs," on the other hand, are portrayed as worthy, and in fact much

131 "Soaring Bad Debts and Illegal Aliens," 3.

needed immigrants who are being treated unfairly and deserve restoration of their good name. This neat dichotomy, however, has not always been the case. Images of the "good" and "bad" immigrant have been used in complex ways by parties with stakes on all sides of the debate over the place of international medical graduates in the US healthcare system. As I will demonstrate using historical examples of contention over IMGs[132], these highly charged rhetorical images have been intertwined with ostensibly technical and factual debates about physician supply and rational planning, often distracting from the discussion of profound problems in the American medical profession and the system in which it is embedded.

Essentially, I am asking what is at stake when voices in American medicine and American society broadly discuss the role of IMGs and what they are doing when they put forward the myriad rhetorical images of IMGs as "good" and "bad" migrants. Debates about foreign medical graduates implicate issues that arise during times of fundamental contention about immigration as well as about healthcare. Often the debates about IMGs become proxies for what is at stake for American society and its values about citizenship and belonging both as a dimension of who deserves to give and to receive healthcare. IMGs become visible at historical moments that form a nexus between these two debates in American culture. Thus the great depression/WW2 era, the 1970s, and the 1990s are not arbitrary time points, but represent moments of real or potential change in how Americans thought about both healthcare and the role of immigration in American culture.

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[132] FMG, or "foreign medical graduate" was the accepted term for internationally educated physicians from the 1960s until sometime in the late 1980s when it was replaced by the term IMG or "international medical graduate." The reason for this shift will be discussed later in the chapter. This project will use the terminology of the time period being discussed in an attempt to streamline the discussion and avoid confusion.

BEFORE FLEXNER: THE RELATIONSHIP OF AMERICAN MEDICINE TO INTERNATIONAL EDUCATION IN THE NINETEENTH CENTURY

Much of the story I will tell in this chapter is of an uneasy and sometimes hostile relationship between the leaders of American medicine and internationally trained physicians coming to practice in the United States. However, this has not always been the case. These discourses have always been intimately intertwined with the process of medical professionalization in the United States and the attendant attitudes shaped by the development of organized medicine organizations such as the AMA, the AAMC, and the Federation of State Medical Boards. Thus the history of American medical professionalization is vital to contextualizing the history of foreign-trained physicians in the US. As late as the 1920s, receiving a medical degree or some level of medical training from abroad was considered a marker of prestige.[133] By the 1930s the attitude was almost entirely reversed, with the institution of exams and citizenship requirements as barriers to the influx of foreign-educated physicians. These changes reflected profound shifts in the structure of American medical education and the growing power of organized medicine; however, they were also strongly shaped by nativist and isolationist attitudes predominant in broader American culture at the time.

Throughout the 18th and 19th centuries, the US was much more likely to be a point of departure, rather than a destination for physicians who went abroad for educational opportunities not available in their own countries.[134] As early as 1800 a "sojourn in Edinburgh or London" for medical study was a marker of prestige for a "handful of

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[133] Eric D. Kohler, "Relicensing Central European Refugee Physicians in the United States, 1933-1945," *Simon Wiesenthal Center Multimedia Learning Center*, Annual 6, Chapter 1. Accessed April 9, 2015. http://motlc.wiesenthal.com/site/pp.asp?c=gvKVLcMVIuG&b=395145.

[134] American Medical Association position paper. "International medical graduates in American medicine: contemporary challenges and opportunities." http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf. Accessed August 9, 2013.

successful urban practitioner-consultants," who formed the relatively tiny elite of the American medical profession.[135] At least in the early years, not all of these physicians returned home, with 11 of the first 20 graduates of the Massachusetts Medical College (later to become Harvard Medical school) permanently relocating to England.[136] Since the colonial era, physicians who did return from their studies abroad "brought back with them the ambition to create in America a profession with the standards and dignity that physicians in Europe possessed."[137] Toward the latter half of the 19th century, these budding members of the American medical elite joined a growing multinational contingent traveling to European countries in pursuit of medical education.[138] Preferred destinations for American physicians varied over the course of the 19th century, shifting to countries that were perceived to be doing the most innovative work in medicine and science.[139] [140] Initially following colonial and cultural ties to Britain in the late 1700s, American students "made Paris their first choice for post-graduate medical study" for the "first three quarters of the 19th century."[141] French professors, such as Pierre Louis eschewed humoral theories and re-aligned medicine's foundations with anatomy and clinical observation. Also, the radical empiricism of the French school accorded well the practical spirit of post-Jacksonian American physicians and their patients.[142] As Alabama physician John Y. Bassett wrote home from his yearlong period of study in Paris in 1836,

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[135] George Rosen, *The Structure of American Medical Practice, 1875-1941* (Philadelphia, PA: University of Pennsylvania Press 1983), 3.

[136] Thomas D. Dublin, "The Migration of Physicians to the United States." *The New England Journal of Medicine* 286, no. 16 (April 20, 1972): 875.

[137] Paul Starr, *The Social Transformation of American Medicine* (New York, NY: Basic Books,1982), 39.

[138] Thomas Neville Bonner, *Becoming a Physician: Medical Education in Britain, France, Germany, and the United States, 1750-1945* (Baltimore, MD: Johns Hopkins University Press, 2000), 315.

[139] Starr, *The Social Transformation,* 39.

[140] AMA, "Contemporary Challenges," 7.

[141] Kenneth M. Ludmerer *Learning to Heal: The Development of American Medical Education* (New York, NY: Basic Books, 1988), 29.

[142] Starr, *The Social Transformation,* 55.

"Americans were not scarce," with "four or five from New York, two from Baltimore, and several from Boston and Philadelphia."[143]

However, by the mid-1800s, French empiricism and the therapeutic nihilism that came with it began to feel outdated. By the 1860s, Germany came to "replace France as the new mecca of the medical world."[144] Nearly 15,000 American physicians traveled to Germany and other German-speaking countries such as Austria and Switzerland between the 1870s and the outbreak of WW1 in 1914. They were not alone, however, with students from "England, Italy, Greece, Turkey, Russia, Japan, and Latin America," studying by their side.[145] Students were attracted by the novel and exciting way German physicians had incorporated laboratory studies and scientific innovation into medicine, using cutting edge work in fields such as biochemistry, pathology, and bacteriology to inform clinical practice. Working with luminaries such as Rudolph Virchow and Robert Koch, "those who studied in Germany became the leading physicians of their generation," according to historian Kenneth Ludmerer.[146] Prominent physicians and future leaders of medical education such as William Welch and William Osler participated in the pilgrimage that had come to be expected of more privileged medical students. Upon returning from a two year sojourn in Berlin and Vienna, studying with "the master mind of Virchow" at his "splendid pathological institute," Osler, like many other future leaders of his pivotal generation of American clinicians, returned to North American to begin an influential academic career.[147]

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[143] Osler, William. *An Alabama Student and Other Biographical Essays*, (New York, NY: Oxford University Press American Branch, 1908,) 7.

[144] Ludmerer, *Learning to Heal*, 32.

[145] Ludmerer, *Learning to Heal*, 32.

[146] Ludmerer, *Learning to Heal*, 33.

[147] Michael Bliss, *William Osler: A Life in Medicine* (Oxford, UK: Oxford University Press, 2007),77.

AMERICANIZING THE GERMAN MEDICAL CURRICULUM: ORGANIZED MEDICINE AND THE FLEXNER REPORT

Like Osler, other alumni of the central European experience came to occupy crucial roles on the faculty of leading American universities such as Johns Hopkins, Harvard, Michigan, and Cornell, and facilitated the introduction of a German-inspired medical curriculum in the late 19th century.[148] These physician-scientists were often frustrated on their return to the US, where medicine remained a practical profession, medical research had little place, and medical education was largely dominated by proprietary schools of varying quality. Beginning in the 1870s with Harvard, however, elite universities built stronger links with medical schools, and these physicians were ideally placed to bring many of the principles of their German medical educations into the curricula they implemented. Thus, following the German example, these elite institutions raised admission standards, contracted their student bodies to allow for more individualized instruction, required scientific education and laboratory-based coursework of their graduates, and built relationships with hospitals to increase opportunities for clinical clerkships.[149] The elite institutions that pioneered these reforms formed a body of mutual oversight which would later become the American Association of Medical Colleges (AAMC.) The AMA, which had itself recently consolidated its power among American physicians, came to strongly support these reforms, advocating for them as a new standard for medical education. The AMA's motives, however, ostensibly focused on raising the quality of medical education, were complex. As Paul Starr argues, the endorsement of these new quality standards was aimed at shutting down commercial medical schools, arguing that they were "undesirable on at least two counts: for the added

148 Ludmerer, *Learning to Heal*, 33.

149 Starr, *The Social Transformation*,114-115.

competition they were creating and for the low image of the physician that their graduates fostered."[150] In 1910, working with Carnegie foundation to produce a neutral-appearing, expert report, the AMA fostered educator Abraham Flexner to visit every medical school in the United States and Canada, evaluating them based on the German-inspired standards of Harvard and Johns Hopkins.[151]

As leading medical historians have acknowledged, the importance of the Flexner report was more symbolic than practical. Paul Starr, for instance, demonstrates that the changes Flexner advocated were already underway long before his tour of inspection. As Ludmerer argues "contrary to a popular myth, Flexner made no intellectual contribution to the discussion of how physicians should be taught. The ideas he popularized to the public were those that had developed within medical faculties in the 1870s and 1880s." The value of the Flexner report, however, was making medical education reform a popular "cause celebre," "transforming what had previously largely been a private matter within the profession into a broad social movement similar to other reform movements of progressive era America."[152] The symbolic role of the Flexner report, as well as the ongoing influence of its author as the newly appointed chairman of the Rockefeller Foundation, which continued to shape American medical education through extensive philanthropic contributions to its chosen institutions, had powerful repercussions for medical education and organized medicine in the US.[153] The report's "high minded" assertions about medical training as a public good and about the role of science in medical education have become common-sense claims among many physicians, medical

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[150] Starr, *The Social Transformation,*117.
[151] Starr, *The Social Transformation,* 118.
[152] Ludmerer, *Time to Heal*, 5.
[153] Rosen, *The Structure of American Medical Practice,* 66.

educators and policy makers.[154] Most important to this discussion, Flexner's report articulated an imperative to rationally limit the number of physicians in training and practice within the country, and that such a limitation was in the public's best interest. "It seems clear," he argued that as nations advance in civilization, they will be driven to throw around admissions to [the] great professions such safeguards as will limit the number of those who enter them to some reasonable estimate of the number who are actually needed."[155] The consequences of not doing so in medicine are deleterious to both the profession and the public, he argues:

> In a town of two thousand people one will find in most of our states from five to eight physicians where two well-trained men could do the work efficiently and make a competent livelihood. When, however, six or eight physicians undertake to gain a living in a town which can support only two, the whole plane of professional conduct is lowered in the struggle which ensues, each man becomes intent on his own practice, public health and sanitation are neglected, and the ideals and standards of the profession tend to demoralization.[156]

As I will argue more exhaustively in chapter five, the conclusions of the Flexner report, and the explicit and implicit principles it espoused served a complex array of interests. However, most relevant to this historical narrative, the values that the Flexner report reinforced came to have an almost ideological force in defining the world view of medical educators and of organized medicine for over a century. Among Flexner's basic tenets was the importance of limiting physician supply at the source, by restricting entry to medical school. The techniques to effect this restriction were to raise educational quality. "Surplus" physicians were by definition tarred as lower quality physicians, any

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[154] Starr, *The Social Transformation,* 120.

[155] Abraham Flexner, *Medical Education in the United States and Canada Bulletin Number Four (The Flexner Report),* Carnegie Foundation | *eLibrary* |. Accessed April 9, 2015. http://archive.carnegiefoundation.org/publications/medical-education-united-states-and-canada-bulletin-number-four-flexner-report-0. XIV.

[156] Flexner, *Bulletin Number Four,* XIV.

physicians who could not achieve the higher bar had no business in medicine in the first place. Organized medicine embraced this "professional birth control" approach, and worked with major philanthropic foundation partners to bring it to fruition. These principles, after all, expressed in the commonsense language of efficiency and public good reinforced the "seller's market" in medicine, and in times of stress, this rhetoric of restriction and quality has had a powerful tendency to resurface.[157]

By these standards, both the mainstream of the medical profession and the American public saw medical education reform in the US as a resounding success. By 1931, triumphantly tracing the progress of American medical education from "the worst in industrialized civilization to the very best," self-congratulatory medical educators dubbed the US system "the marvel of the educational world."[158] Indeed, exam scores had gone up markedly, as had measures of public confidence in allopathic physicians, missing from these assessments, however, were growing built-in flaws of the system.[159] Among those were consequences for the make-up and distribution of the physician population. As minimum standards for laboratory and clinical experience grew, so did the cost of medical education. Likewise, increased time requirements for pre-medical education effectively priced out students from working class backgrounds.[160] Furthermore, the closure of medical schools deemed to be of lower quality, or too underfunded to be effective, disproportionately affected blacks, women, and immigrants who were just beginning to gain a foothold in the ranks of the American medical profession. As many have argued, these deficiencies have led to a proportionate drop in the awareness of these

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157 Rosen, *The Structure of American Medical Practice,* 73.

158 Kenneth M. Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care*. (Oxford, UK: Oxford University Press, 1999), 3.

159 Ludmerer, *Learning to Heal*, 94-95.

160 Rosen, *The Structure of American Medical Practice,* 67.

patient populations and affected the quality of care they have received.[161] Concomitant with this mostly quiet whitewashing of American medical practice, another trend, the increasing urbanization and specialization of American physicians began to cause alarm by the 1920s, even for Flexner himself.[162] The increasing cost of medical education made less profitable rural practices much less attractive to medical graduates. Many small towns found themselves without any doctors at all.[163] This rural-urban divide as well as the challenge of providing care to disenfranchised populations has haunted American medicine to the present day, challenging the common sense of academic medicine's Flexnerian outlook.

AMERICAN MEDICINE'S FIRST FOREIGNER CONTROVERSY: SECOND GENERATION AMERICAN MEDICAL STUDENTS DURING THE GREAT DEPRESSION

Another irony of these turn of the century reforms, was that transforming American medical education on an international model would eventually lead to an attempt to close the doors to international physicians. By the 1890s, as quality medical research and education opportunities became more available in the United States, teachers began advising medical students there was no need to study abroad, and the numbers of American students traveling to Germany and Austria fell correspondingly. The years after 1900 even began to see a small reverse exchange of Germans coming to do research at American medical schools.[164] World War I put an abrupt end to much of American and German medical cooperation. Furthermore, the War ravaged the great universities of European countries, leaving them struggling and underfunded. The new

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[161] Starr, *The Social Transfromation,*124.
[162] Ibid.
[163] Ibid.
[164] Ludmerer, *Learning to Heal*, 99-100.

"smugness" of American medicine became apparent as the Rockefeller foundation, which just 10 years earlier supported the import of French and German medical education as models for the American system, launched initiatives in the 1920s to reform French Medical education and bring it closer to the American system.[165] However, during these prosperous times, though foreign study did not carry its former cache, it was not yet looked down upon, and there seemed to be little need to pay any special attention to physicians coming into the country.

Physicians arriving from abroad suddenly became more visible in the context of the Great Depression when the livelihoods of many American physicians felt threatened.[166] As a Gallup poll of the time demonstrated, families who lost substantial income during the depression called upon physicians half as often as before, and physicians, particularly those who served small communities of working and middle class families began to feel the strain, seeing their incomes drop by as much as 47%.[167] This phenomenon was doubly concerning for organized medicine groups like the AMA because of impending New Deal legislation and the growing social push for government-funded health insurance. On record as staunch opponents of what they labeled as "socialized" or "state" medicine as a threat to physicians' autonomy and professional self-rule, the cadre of elite urban specialists who headed the AMA grew concerned about a possible rift with the "'little men' of their profession," who might potentially come to see a government plan as relief for them as well as their struggling patients. Dissent also came from above, with a group of 430 major figures at academic medical centers forming

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[165] William H. Schneider, *Rockefeller Philanthropy and Modern Biomedicine: International Initiatives from World War I to the Cold War* (Bloomington, IN: Indiana University Press, 2002), 109-110.

[166] Rosen, *The Structure of American Medical Practice,* 70.

[167] Starr, *The Social Transformation,* 270.

the Committee of Physicians for the Improvement of Medical Care, a group that advocated for more equity and a stronger government role in the distribution of medical care.[168] [169]

Spurred by this perception of crisis the AMA and the AAMC convened a Committee on Medical education that reinforced a 20-year-old logic: that the true reason medicine was suffering was because there was a surplus of physicians, and that their numbers had to be urgently cut, both for the good of the profession and the good of the public. Much as Flexner insisted in his 1910 bulletin, the committee's report warned, "an oversupply is likely to induce excessive economic competition, the performance of unnecessary services, an elevated cost of medical care and conditions in the profession which will not encourage students of superior ability and character to enter the profession."[170] As historian George Rosen notes, this was also the first time a recommendation about physician supply referenced reducing both the numbers of incoming medical students and physicians arriving from abroad.[171]

The reasons for the sudden appearance of foreign-trained physicians as a unique category had complex roots, and at the time had as much to do with American attitudes toward immigrants as events within medicine *per se*. Although medical expertise had ruled that there was a surplus of physicians, the prevailing social attitudes of the time determined which aspiring physicians were deemed less worthy of joining the profession. Historian John Higham described the 1920s as a high point in American xenophobia,

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[168] Starr, *The Social Transformation,* 270-271.

[169] Peter J. Kuznick, *Beyond the Laboratory: Scientists as Political Activists in 1930's America* (Chicago, IL: University of Chicago Press, 1987), 87.

[170] AMA, 1932 in Rosen, *The Structure of American Medical Practice,* 67.

[171] Rosen, *The Structure of American Medical Practice,* 71.

nativism and isolationism, dubbing the era the "tribal 20s."[172] In the 1870s, what became known as the Second Great Wave of immigrants, mainly from Eastern and Southern Europe began arriving in the United States.[173] By 1920, the total volume of these migrants exceeded the total US population in 1850. Many Americans found both the sheer volume and the apparent cultural otherness of these new immigrants disturbing. A congressional study of these new immigration concerns in 1907, for example, labeled some of these groups, in particular Eastern European Jews and Italians as "less assimilable."[174] This foment of nativist sentiment at the highest reaches of American society lead to a series of restrictive laws, among them a 1917 act that restricted all Asian migration, and the Quota acts of 1921 and 1924, that specifically restricted Eastern and Southern European immigrants.[175] [176] The backlash that led to the passage of these laws, however, fueled conceptions of the inferiority and unassimilability of these groups.

Physicians, like many Americans of their social standing were hardly immune to these sentiments. In an editorial in *American Medicine* published in 1924, Walter L. Niles, dean of the Cornell University school of medicine, commented on a trend he found deeply disturbing: "In these days the children of the foreign born acquire sufficient education thru (sic) the public school system…to enter medicine with satisfactory standing." "Such matriculates ought to be discouraged," he argues, as they "uniformly lack culture," and do not have "a satisfactory background for such an exalted profession

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[172] Rosen, *The Structure of American Medical Practice*, 67.

[173] Louis DeSipio and Rodolfo O. de la Garza, *U.S. Immigration in the Twenty-First Century: Making Americans, Remaking America* (Boulder, CO: Westview Press, 2015), 66.

[174] DeSipio and Garza, *U.S. Immigration*, 74.

[175] DeSipio and Garza, *U.S. Immigration*, 75-76.

[176] Interestingly, a major group not restricted at this time were immigrants from South and Central American who were permitted to travel relatively freely across the Southern border.

as medicine."[177] Progressive definitions of "quality," it seemed, did not sufficiently exclude newcomers that the medical mainstream found undesirable. Unable to limit the social and ethnic make-up of medical schools based on objective standards of education and exams, deans added assessments of "personality and character" to the admissions process. As Rosen argues, these subjective assessments were effectively used to exclude students on ethnic, racial, and class grounds.[178] Informal quotas for Blacks, Italians, women, and Jews became a well know but little spoken of norm in medical school admissions.[179]

The most restrictive and contentious quotas, however, were reserved for Jewish students. Almost never formally acknowledged, these quotas existed at every step of the medical education process from undergraduate, to medical school, to residency training and the acquisition of hospital privileges.[180] As historian Eric D. Kohler contends, medicine was a popular career choice for young Jews and their families both in Europe and the US. Seeing medicine as a path to stability and social mobility, many highly qualified Jews, particularly from the ethnic enclaves of New York sought admission to medical schools. The quota system, however, took its toll, at a time when 3 of 4 applicants to medical school were successful, only one of twelve Jewish applicants was admitted.[181] Many of these students, along with Italians and other ethnic minorities traveled to Europe for their medical educations. As Kohler argues, "with more than 9,000 Americans studying abroad between 1930 and 1936, the American medical establishment, fearful of this competition, embarked on a campaign to devalue foreign

[177] Walter L. Niles, "Shall the Poor Boy Study Medicine?" *American Medicine* July 1924: 426.
[178] Rosen, *The Structure of American Medical Practice,* 69.
[179] Ludmerer, *Time to Heal,* 63-64.
[180] Ludmerer, *Time to Heal,* 63-64, 94.
[181] Ludmerer, *Time to Heal,* 64.

medical credentials. Within a decade the German or Austrian medical degree, once the cachet of superiority, became the badge of the second-rate."[182] Although leading physicians who had proudly studied at these same universities were still in the workforce, the absurdity of these claims garnered little attention. As Rosen notes "logical consistency was not…the major concern" of the American medical establishment in the 1930s, which was preoccupied with "stabilizing the medical market" as well as staving off government health insurance.[183] [184] Thus "efforts to stamp American students abroad as inferior" were joined with efforts to place impediments in the way of their return. Though as late as 1929 an AMA report stated that "…medical education in the United States is now on a par with the requirements of other countries," by the 1930s, commentators repeatedly pointed out that students studying in Europe "were rejected on the basis of competitive selection for admission to our medical schools, and to this extent, at least, they must be considered as constituting an inferior group."[185] [186] The same author continues "we must frankly face the question as to whether or not at least some of these students may not be exposed to a professional training which is in many ways inferior to that now required in the United States."[187] Evidence to support the later contention came in the form of studies of dropping licensing exam pass rates by European graduates, included in the 1932 final report of the AMA's Commission on Medical Education. As Rosen points out however, these studies failed to distinguish foreign born physicians with potential language and cultural barriers form returning Americans. Responding to these

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[182] Kohler, "Relicensing Central European Refugee Physicians," no pg.

[183] Rosen, *The Sturcture of American Medical Practice,* 76.

[184] Starr, *The Social Transformation,* 271.

[185] David L. Edsall, N.C. Tryon, and Tracy J. Putnam. "The Emigre Physician in America, 1941; A Report of the National Committee on the Resettlement of Foreign Physicians." *JAMA* 117, no. 22:. 1877.

[186] Rosen, *The Structure of American Medical Practice,* 77.

[187] Rosen, *The Structure of American Medical Practice,* 77.

pressures, by 1940, the medical boards of all but two states had instituted some impediments to licensure for physicians coming from abroad.[188] A contemporary publication classified these barriers as "those making a requirement of citizenship and those making a prerequisite for licensure that may be difficult or impossible…to meet."[189] All Americans returning from abroad after 1932-1933 were required to show that they had completed US equivalent pre-medical coursework. Additionally they were required to show a license to practice medicine in their countries of training. This requirement was intentionally virtually impossible to meet, as many European countries did not license foreign students.[190]

REFUGEE PHYSICIANS: PROTECTIONISM AND ADVOCACY

This increasingly tense struggle, previously limited to medical insiders, became publicly visible by the late 1930s. By 1938, in addition to second generation Americans returning from abroad, 1,538 refugee physicians, three quarters of them Jewish, entered the United States escaping persecution in Nazi Germany and Austria.[191] Some of the earliest anti-Jewish policies of the Nazi regime were aimed at Jewish professionals and academics, thus these groups formed the vanguard of the refugee waves that left to home in search of safety and continued livelihoods.[192] Upon arrival, many of these physicians congregated in New York, but soon began to spread out across the country in search of employment. In many cases, these physicians, the first distinct group of truly foreign medical graduates in the US, were greeted by the protectionist and nativist attitudes that

188 Edsall, "The Émigré Physician in America," 1885.
189 "Refugees and the Professions." *Harvard Law Review* 53, no. 1 (November 1, 1939): 112–22.
190 Rosen, *The Structure of American Medical Practice,* 77.
191 Edsall, "The Émigré Physician in America," 1886.
192 "Foreign Letters: Vienna." *JAMA* 112, no. 24 (June 17, 1939): 2546–47.

had already been fomenting throughout the depression. Many state medical societies quickly campaigned for new legal and professional barriers aimed at this additional group of newcomers. The Arkansas legislature for example, announced that "an 'emergency' arising from 'troubled conditions in Europe,' necessitated the imposition of citizenship requirements on applicants desiring to practice medicine."[193] By 1940, all but 15 states required American citizenship for students to be able to sit for licensure examinations.[194]

Along with generating mistrust and sometimes frank enmity from more traditional branches of the medical establishment, however, these physicians eventually garnered a few vocal and savvy supporters, who advocated for their legitimacy within the frameworks of national and professional discourses. The leading group in this movement called itself the Committee for the Resettlement of Foreign Physicians, and began as a liaison of subcommittees in major Eastern cities such as Boston, New York and Chicago.[195] Among these, the Boston committee, chaired by retired Harvard dean David Lynn Edsall, was perhaps the most influential, with Edsall serving as spokesman of the movement to the rest of the medical profession and as first author of many of its publications.[196] By 1941, the movement had reached farther afield, with committees or cooperating bodies in Virginia, Missouri, California, Colorado, Texas, Louisiana, Tennessee, Minnesota, Ohio and Pennsylvania.[197] Although many of the committee's more active members were drawn from Academic medicine's Jewish minority, the committee continually emphasized its "non-sectarian" nature, noting that many of the

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193 "Refugees and the professions," 112-113.

194 Kohler, "Relicensing Central European Refugee Physicians," no pg.

195 Edsall, "The Émigré Physician in America," 1985.

196 Though not as famous today, Edsall was known for his research and clinical achievements. He was the first non-harvard man to be appointed to the Harvard medical faculty and played a prominent role as a long time trustee of the Rockefeller foundation.

197 Edsall, "The Émigré Physician in America,"1882.

refugees it was assisting were protestant and Catholic, and choosing many of its non-Jewish members as spokespersons.[198] David Edsall, as the chairman of the Boston Committee, was a good example; though jokingly rumored to be Jewish because of his first name and his Democratic politics, Edsall was very much a member of the establishment.[199] Meyer Bodansky, a professor of Pathology at the University of Texas Medical Branch worked to organize the Texas chapter of the organization, and continually referenced the need to find an appropriate balance of Jews and gentiles, telling a correspondent, "I believe the best plan would be to decide on some outstanding non-Jewish physician who is entirely sympathetic," for the chairmanship of the Texas committee.[200]

Much of this caution was a negotiation with the political climate of the time, particularly within medicine. Many of the prominent academics who became involved with the work of the committee, however, saw larger stakes in its mission than the careers of the approximately 5,000 refugee physicians who had re-settled in the United States by the end of the WW2. The committee's work on behalf of European refugees included a public relations campaign that projected not only different images of migrant physicians, but also a different overall vision of American medicine than that of the conservative wing of the AMA. The committee's work, both on a broad and on an individual scale involved countering the prevailing image of these refugees as inferior physicians and dangerous aliens, instead putting forth a rhetoric that resonated with American images of

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198 Edsall, "The Émigré Physician in America,"1882.

199 Joseph C. Aub and Ruth K. Hapgood, *David Lynn Edsall of Harvard: Pioneer in Modern Medicine*. (Boston, MA: Harvard Medical Alumni Association, 1970).

200 Meyer Bodansky, and Herbert Mallinson, "[Letter from Meyer Bodansky to Herbert Mallinson - June 22, 1939]." Letter. *The Portal to Texas History*, June 22, 1939. http://texashistory.unt.edu/ark:/67531/metapth228665/m1/1/?q=Bodansky.

the "good immigrant." Just as important to their work, however, was to counter rhetoric of a physician surplus and impending medical unemployment. Repeatedly highlighting the growing rural-urban maldistribution of physicians, the needs of smaller communities and marginalized groups, as well as war-time scarcity, the committee offered refugee physicians as a solution to these problems. In citing these examples, however, they also brought into question whether the unfettered professional self-regulation of the past 40 years had been what was best for the profession and the public. Many of the solutions this group proposed, for example a new role for the committee, and perhaps later for the Public Health Service in ensuring equitable physician distribution, revealed a willingness to consider a greater government role in regulating American healthcare. In this light, it is perhaps unsurprising that the Committee for Medical Refugees drew support from the same pool of Academic medical leaders as the Committee of Physicians for the Improvement of Medical Care as well as the left leaning Physicians' Forum. For example, Ernst Boas, a physician from Columbia and Mt. Sinai noted as much for his work in cardiovascular physiology as for his support of progressive causes, was a member of all three organizations.[201]

Throughout the 1940s, the committee members served as a support network, helping refugee physicians prepare for licensure requirements, finding them internship and laboratory positions, and when possible setting them up in practice, often in small towns throughout the United States.[202] Some of the work of the committee included administrative and advisory tasks, assessing the qualifications of new arrivals, helping them pay their bills while they studied for exams as well as arranging for lessons on "the

[201] Also the son of Franz Boas, the anthropologist

[202] Kohler,"Relicensing Central European Physicians," no pg.

broad cultural requirements of American medicine."[203] Much of the day to day work of the committee and its members consisted of networking—using personal connections and information networks to find placements for individual physicians. Meyer Bodansky, as a professor at UTMB, fielded dozens of letters on behalf of refugees, making inquiries, calling in favors, and drawing on professional and personal relationships to find clinical and lab jobs for these individuals. Often he was unsuccessful. Another physician, Otto Saphir of Michael Reese hospital in Chicago arranged for internship and externship spots at his hospital specifically to allow émigré physicians to fulfill new licensure requirements.[204] The committee had placed 500 physicians in small town and rural private practices, "villages from which the previous doctor had moved, and farming areas with few physicians, some aged," boasting that some of these communities "are enjoying better medical care than they had before." Places, the committee argued, where they cause "the least dislocation of other established practices and render the best service."[205] In a recent memoir, Eleanor Sontag, a child of one of these refugee physicians, describes how her father chose to establish a practice in Homer, New York, "a Norman Rockwell Village" of 3000. Her father purchased a home and built up a general practice. Initially denied hospital privileges because of his German background, he eventually became a part of the community, and although "it was a far cry from [his former] chic, sophisticated life…in metropolitan Berlin," he stayed in Homer for much of his career.[206]

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[203] Edsall, David L. "A Program for the Refugee Physician." *JAMA: The Journal of the American Medical Association* 112, no. 19 (May 13, 1939): 1986–87. 1986.

[204] Kohler, "Relicensing Central European Physicians," no pg.

[205] Edsall, "A Program for the Refugee Physician,"1986.

[206] Sontag, Eleanor, *Second Generation* (Bloomington, IN: Xlibris Corporation, 2011), 36-37.

Another major function of the Boston committee and the broader committees for medical refugees was to do PR work on the behalf of refugee physicians. Working with both the popular and professional media, these advocates' rhetorical styles placated prevailing fears as they challenged misconceptions. The committee's work fit into a larger effort to rehabilitate the image of the immigrant—challenging residual nativist sentiments remaining from the anti-immigrant backlash of the 1920s, depression era fears of economic competition, and wartime questions of allegiance and loyalty. In both popular and professional publications, these advocates put forth alternative images of the "good immigrant," one that emphasized potential economic productivity and a fundamental eagerness to assimilate. The first challenge was to distinguish wartime refugees from immigrants of previous generations. As one American physician argued in a popular science periodical, those calling to further exclude refugees "are still laboring under the impression that hordes of unwashed, illiterate people are clamoring at the gates." "Immigrants today," he counters, "are to a large extent people of culture. A large proportion is made up of professional people such as doctors, dentists, nurses, and research workers."[207] Likewise a JAMA article compares physician migrants favorably to the "unselected millions who used to pour into our country from every section of Europe."[208]

Many efforts on behalf of refugees focused on educating the public about their numbers. A 1947 publication, for example, emphasizes that the total number of war refugees admitted into the US was around 200,000, which compared to past immigration constituted "the smallest in any comparable period in the last 100 years," with only

[207] "Refugee Doctors Idle." *Science News-Letter* 43, no. 13 (March 27, 1943): 197–98.
[208] Edsall, "The Émigré Physician in America."1884.

16.8% of Europe's quota used in the years 1933-1944. The author also challenges the "alleged flood" of Jewish immigrants, citing total wartime admission of Jewish immigrants at half the number of Jews admitted in the 1920s alone.[209] In medicine similar rumors abounded, with a 1939 issue of *Medical Economics* fearing the entry of 25,000 refugee physicians a year. A *Time Magazine* article countering this report drew on Edsall and the Boston Committee's statistics, citing the total number at the time to be closer to 1,500.[210] Like more general articles on the refugee, Committee publications emphasized the fundamental assimilability and economic usefulness of these newcomers. In a 1941 JAMA article, Edsall and colleagues critiqued the new rash of state licensing restrictions, arguing that "in incomprehensible isolation, legislators and others build bars around their own small domains, arbitrarily cutting off those valuable immigrants whose professional ability could contribute to the health of the entire nation."[211] At the same time, they recognized the fears of these legislators, making repeated assurances that their programs of physician resettlement took great care to avoid creating competition for native doctors.[212] Edsall and colleagues also make a point of addressing accusations of inferior ethics on the part of foreign physicians, attributing them to "prejudice, unfriendliness, and unwillingness to make allowance for the period of adaptation and assimilation necessary to transform an immigrant into an American."[213] This period, they argue, is very brief, and many of the physicians they placed are already becoming a part of their communities, citing that "several alien doctors are members of local fire

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[209] Maurice R. Davie, "Recent Refugee Immigration from Europe." *The Milbank Memorial Fund Quarterly* 25, no. 2 (April 1, 1947): 191.

[210] "Refugee Physicians." *Time Magazine* 31, no. 7 (February 13, 1939): 46.

[211] Edsall, "The Émigré Physician in America," 1881.

[212] Edsall, "The Émigré Physician in America,"1882.

[213] Ibid.

departments…several are members of the local Grange and Rotary clubs; and a number of wives are members of local women's organizations and church groups."[214] In addition, the article mentions that many of these physicians are eager to serve in the armed services but are currently barred. Such service, they argue would "give spiritual as well as legal validity to their applications for citizenship."[215] These physicians and their families, they continue, are already "well on their way to being good, normal American citizens."[216] Despite experiencing prejudice and facing social and professional impediments, these physicians are portrayed as "very humble and very grateful." Thus, their advocates portray these physicians as more likely to contribute to society than take from it. As a 1947 article emphasized, "it is significant that no refugee had to be deported as a public charge."[217]

Integral to the Committee on Medical Refugees' advocacy for émigré physicians was the need to systematically counter the firmly and widely held belief among the mainstream of American physicians that there was a dangerous surplus of medical manpower in the United States. As discussed above, this belief was strongly reinforced by the AMA medical educational committee report of 1932 and other organized medicine publications. State medical boards reinforced these images, arguing that there was no work to be had for foreign physicians and that wherever they settled they only created destructive competition for native graduates. As a member of the Texas State Board of Medical Examiners put it, of the 25 foreign physicians that managed to get credentialed in the state, by his estimation, "every one of them [that is, refugee physicians], unless he

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[214] Ibid.
[215] Ibid, 1887.
[216] Ibid, 1883.
[217] Davie, "Recent Refugee Immigration from Europe," 194.

has an uncle with a big store, is starving in the practice of medicine."[218] Edsall and colleagues challenged this scenario, emphasizing the growing maldistribution of physicians and bringing to light urgent shortages throughout the nation. "There is no doubt," they argue, "that we are facing an increasing shortage of native physicians."[219] "While the general population of the United States has increased, the medical census has not kept pace," they argue.[220] The number of medical schools in the US had been decreasing since the turn of the century. Depression era cuts in entering classes stemmed the domestic production of physicians still further. In this seller's market, fewer and fewer physicians chose to settle in smaller towns and rural areas. This maldistribution became glaringly apparent in some states, with a few seeing a 30-50% reduction in physicians while their populations continued to grow.[221] Although the authors admit that "the committee knows no standard reference to determine the ideal ratio of physicians to population," some state ratios were obviously egregious, for example, Alabama, Arkansas, West Virginia, and Oklahoma, which all had physician to population ratios well under 1:1000. "Yet despite the obvious need," the committee remarks, many of the medical boards in these very states have insisted on passing restrictions to keep foreign medical graduates out. How these types of policies, "can be construed as in the interest of the public welfare is difficult to see."[222]

The work of the Boston Committee was in many ways frustrating though ultimately fairly successful. Although many of the medical refugees it advocated for

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[218] Kohler, "Relicensing of Central European Physicians," no pg.
[219] Edsall, "The Émigré Physician in America," 1885.
[220] Ibid.
[221] Ibid.
[222] Edsall, "The Émigré Physician in America," 1887.

found work, many restrictive depression-era laws and policies remained on the books. Its work did not end with the cessation of hostilities in WW2 however, as refugees and "displaced persons" continued to arrive in the United States into the 1950s.[223] The image constructed for foreign and foreign trained physicians in this era, had a remarkable staying power in later American debates. The terms of these debates over this first large, visible group of foreign physicians in the United States laid the groundwork for future controversies about foreign medical graduates and their roles in the US healthcare system. When foreign medical graduates again became the subject of widespread attention in the 1970s and the 1990s, debates brought familiar issues into play. The role of FMGs, for example, has come to be discussed in the context of debates over physician supply. Within that debate however, claims of rationalizing care in the public interest are in tension with claims of protectionism and self-interest. As the decades progressed, the often unspoken subtext of the physician supply controversy has grown louder. At the heart of debates about whether the US has too many or too few physicians, and why they are so poorly distributed to rural and poor areas is the entire foundation of the health system as well as common understandings of the relationship of medical education to the structure of medical practice. The Flexnerian assumption, which has remained largely unquestioned for many decades, presupposes that a not entirely intuitive mix of altruism and market forces will ensure both an adequate supply of physicians and that the profession remains lucrative enough to attract talented individuals. Therefore producing the right amount of highly trained physicians is the major prerequisite for ensuring an appropriate supply of healthcare providers, and thus healthcare for a country or region.

[223] A.M. Burgess, "Resettlement of Refugee Physicians in the United States." *The New England Journal of Medicine* 247, no. 12 (September 18, 1952): 419–23. 420.

The physician supply debate highlights the flaws in these assumptions. It is not surprising that this debate seems to surface at times when the structure of the US healthcare system comes into question. Nor is it surprising that those who question its assumptions are often those interested in changing the system, sometimes radically.

Likewise questions of professional competence arise as well, with claims that FMGs are inferiorly trained and perhaps dangerous countered by accusations of discrimination and chauvinism. Under the surface of this debate, however, are also tensions about the purpose and effects of immigration in the United States. Though once again framed as questions of the public good, these debates often reveal that physicians as a group are in Bioethicist Edmund Pellegrino's words, a "biopsy" of the society around them, reflecting the prejudices and anxieties of their times.[224] Debates about IMGs often arise at moments when questions about immigration come to a head. In some ways, because the nominal issues in question are framed as being for the protection of the public or the integrity of the profession, debates about those perceived to be foreigners within medicine can sometimes more bluntly reveal prejudices and anxieties about certain groups. Lessons from this era have been remembered on select occasions, serving as precedent for efforts to support and assimilate groups of physicians who have been deemed to be refugees. This was the case for Cuban refugee physicians fleeing the Castro revolution in the late 1950s as well as for Vietnamese physicians given asylum after the conclusion of the Vietnam War.[225] The broader, underlying stakes and questions about

[224] Drew University, *Dr. Edmund Pellegrino Talks About Medical Humanities*, 2010. https://www.youtube.com/watch?v=4mrHEKt2HC8.

[225] N T Anh and J F Hammarsten,"The Vietnamese Émigré Physicians in Oklahoma from 1975 to 1977," *The Journal of the Oklahoma State Medical Association* 71, no. 9 (September 1978): 343–50.

the US healthcare system that this debate brought to light, however, would come up in new guises in future decades.

Chapter 3: IMGs in American Medicine at Mid-Century: Growth, Prosperity, and Controversy

Just as foreign medical graduates tend to generate controversy at times of perceived threat for organized medicine and moments of public debate about immigration, they seem to fade into the background as the rhetoric on these issues cools. Two articles in the New York Times, just over 10 years apart, illustrate how radical these shifts could be. In 1957, an article describing the curious presence of "alien" doctors on American hospital wards concludes with the sentiments:

> Just because the house physician caring for you is from another country and may have some difficulty speaking English does not mean he is not a "good doctor." The greatest concentrations of these foreign physicians are in our finest hospitals. The foreign physicians in our hospitals are performing a real service for our country now as our hospitals need them. They will continue to serve the United States upon returning to their own nations. They will be ambassadors, both by example and service of both United States technical skills and the high value we place on human life and individual worth.[226]

A 1967 article in the same newspaper, however, takes a markedly different tone. As an article, somewhat bulkily subtitled "Influx of Doctors rising at 10% a year: Thousands Fail Basic Tests and Practice Unlicensed—Concern is Voiced," presents a much less reassuring picture of foreign physicians:

> The national shortage of doctors and the rising demand for health services has led to the immigration of thousands of foreign physicians, many of doubtful ability who may arrive to practice in American medical institutions sight unseen and quality untested…About 45,000 doctors who were trained in foreign medical schools now reside in this country and the number is increasing at the rate of 10% per year. Many of the foreign doctors, possibly as

[226] Howard A. Rusk, "Foriegn Physicians I: A Report on Reason for the Sharp Rise in Their Presence in US Hospitals," *New York Times*, July 22, 1956.

> many as 5,000 have been unable to pass tests of basic medical knowledge and are practicing without licenses…[227]

The 1967 article goes on to quote Harold Marguiles, a physician representing the AMA, and later the department of Health Education and Welfare who had been a prominent voice in highlighting the "major national scandal that there has been no policing of foreign doctors."[228] In a tone that is a marked departure from the reassurance of 10 years prior, he stated "we have been meeting our manpower shortage in the United States with substandard people who are offering substandard care."[229]

The opposition of these two perspectives begs a number of questions about what changed in the interval. What had so radically shifted the broad cultural attitude toward foreign physicians? Had the training of physicians coming to the United States really deteriorated? In order to trace the origins of this shift, this chapter will examine how FMGs fit into the radical reconfigurations that occurred within American medicine after WW2 and into the "crisis" of medicine of the late 1960s and 70's. One of the major things that did change about FMGs themselves in this era was their demographic make-up, with a greater proportion of them hailing from Asian and Middle Eastern countries as opposed to European nations. This shift prefigured the radical philosophical and policy shift towards immigration and the role of immigrants in American society embodied in the congressional immigration reforms of 1965. This chapter explores how discourses on immigration and changes in the fundamental structure of healthcare provision in the US shaped discourses about international physicians.

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[227] Richard D. Lyons "Foreign Physicians, Many Unqualified, Fill Vacuum in U.S." *New York Times*. September 29, 1967.

[228] Ibid.

[229] Ibid.

INTERNATIONAL PHYSICIANS IN AN ERA OF PROSPERITY AND CONSENSUS: 1950-1965

Just as foreign medical graduates tend to generate controversy at times of perceived threat for organized medicine and moments of public debate about immigration, they seem to fade into the background as the rhetoric on these issues cools. The refugee physicians who entered the US in the 1930s and 40s did not disappear after the end of WW2, nor did new foreign physicians stop coming to the US, but they did pass somewhat to the periphery of public and professional consciousness. Within the first few years after the end of the war, reassessments of refugees from all walks of life, among them physicians, dismissed many of the concerns about their numbers and impact on American society.[230] [231] Although the Truman administration saw a revival of AMA agitation against government health insurance, the organization achieved most of its goals, and the post war years were largely a time of abundance and consensus for American medicine.

Both Paul Starr and David Rothman, another scholar of the period, describe the post-war years as a "bonanza" not only financially, but also in terms of authority and autonomy of the medical profession and its practitioners.[232] This period was marked by the advent of healthcare as "one of the nation's largest industries, as federal funding for research endeavors and hospital construction seemed to grow exponentially with every passing year.[233] In the public eye, medical innovation was an unquestionable good, and as Rothman put it, the public's faith, and escalating amounts of public monies, seemed

[230] A.M. Burgess, "Resettlement of Refugee Physicians in the United States," 419.
[231] Davie, "Recent refugee emigration,"189.
[232] Starr, *The Social Transformation,* 370.
[233] Starr, *The Social Transformation,* 370.

well-placed. The discovery of the "miracle drug" penicillin during World War II and subsequent "extraordinary products " including, "a cure for tuberculosis; a variety of drugs for treating cardiac abnormalities; a new understanding of hepatitis …" were truly impressive.[234] Overall, American medicine after WW2 took an increased "tilt toward technology,"[235]

Instead of comprehensive health reform, the compromise solution was an extensive program of public money to support community hospital construction and expansion, known as the 1946 Hill-Burton act. This program, along with other contemporary trends, shifted the nexus of medical activity even further away from community interventions such as public health and primary care, and toward high technology, hospital-based care.[236] Likewise, the success of large scale war-time research made a powerful rhetorical argument for the continuation of government-funded science in biomedical research, ushering in what Stevens and Vermulen called "the halcyon days of research funding" that lasted into the late 1960s.[237] The move toward the hospital and the bias toward research fed the growth of academic medical centers as well as community hospitals. Enhanced sub-specialization, and the "growing technical capacity of hospital-based medicine led to greatly expanded demands on teaching hospitals for clinical care. With faculty busy managing research laboratories and seeing private patients these demands were increasingly filled by an exponentially growing

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[234] David Rothman, *Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making*, (New York, NY: HarperCollins, 1991), 79.

[235] Starr, *The Social Transformation,* 348.

[236] Starr, *The Social Transformation,* 350.

[237] Rosemary Stevens, and Joan Vermeulen. "Foreign Trained Physicians and American Medicine.," June 1972. http://eric.ed.gov/?q=%22foreign+trained+physicians+and+american+medicine%22&id=ED101930. 14.

cadre of interns and residents.[238] Once reserved for a small minority of medical students being groomed for academic positions, after WW2 residency became "democratized," and by 1970 came to be the expected level of training for nearly all physicians.[239] Numbering just 5,796 nationally in 1940, these interns and residents fulfilled the growing manpower needs of increasingly technologized hospitals. By 1970, there were 46,558 available residency positions.[240] This pool of relatively inexpensive labor became crucial to the ability of many hospitals to function, and clinical departments eagerly added training spots, more for their service than their educational function. As Rosemary Stevens and Joan Vermeulen argue in 1972 Health Education and Welfare (HEW) report, "the line between graduate medical education and hospital staffing may be exceedingly thin." "Quite clearly," they continue, "the hospitals are reaping substantial services in kind in return for the physician's education."[241] As Paul Starr argues, "the profit that doctors and hospitals derived from house staff was one of the driving forces of the postwar medical system."[242]

The fragmentation between entities in the healthcare system resulted in a disconnect: although demand for residents escalated, the number of medical school places remained the same. The Flexnerian logic of controlling physician numbers through limits on entry to medical education remained prevalent among AMA leaders and some medical school deans.[243] In the newly burgeoning hospital system, however, a different logic prevailed, as hospitals found they needed more and more trainees to perform their

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[238] Ludmerer, *Time to Heal,* 183.

[239] Ludmerer, *Time to Heal,* 181.

[240] Ludmerer, *Time to Heal,* 183.

[241] Stevens and Vermeulen, "Foreign-Trained Physicians," xi, 9.

[242] Starr, *The Social Transformation,* 360.

[243] Blumenthal, David. "New Steam from an Old Cauldron--the Physician-Supply Debate." *The New England Journal of Medicine* 350, no. 17 (April 22, 2004): 1781.

expanded and more complex roles. Competition for residents intensified between specialties and between hospitals.[244] In 1958, for example, there were only 6,861 American medical graduates available to fill 12,325 internship positions.[245] Although academic hospitals mostly filled their spots, community hospitals often attracted only half as many house officers as they needed.[246] Thus the WW2 era influx of foreign-trained physicians never abated, but rather became a new norm, as community based programs began to recruit these physicians to their unfilled posts.

The ability to draw on this group of physicians to fill these gaps, however, was largely due a set of federal policies, coincidentally making them available just at the right moment. The Smith-Mundt act, which was to evolve into the Fulbright program went into effect in 1949. Begun as a way to get some use out of military equipment left with foreign governments after WW2, the act proposed that the money reimbursed to the US for this equipment be put into a program that facilitated international educational exchange. With the recent advent of the Cold War, this endeavor had a great deal of foreign policy appeal. The policy was intended to "promote a better understanding of the United States among the peoples of the world." As one sponsor of the bill argued, the fostering of friendly, interpersonal relationships with Americans through individual exchanges could counter the "malicious falsehoods," that the "Russians and others spread about us every day."[247] The act created a new type of visa, the J-1, specifically designated for the group that came to be called "exchange visitors," who were permitted to stay in the country to complete an educational program and go back home afterwards.

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[244] Stevens and Vermeulen, "Foreign-Trained Physicians," 3.
[245] Ludmerer. *Time to Heal*, 185.
[246] Ludmerer, *Time to Heal*, 185.
[247] Stevens and Vermeulen, "Foreign-Trained Physicians," 53.

Regulation of this program was fairly decentralized however, with individual private and non-profit entities expected to serve as the sponsors for these visitors. By 1961 1,300 individual hospitals had joined the program as sponsors.[248] In 1950, the first year of the program, 2,100 physicians came to the US under its auspices.[249]

Some hospital recruitment efforts extended as far as hiring "recruitment teams and commercial firms including airlines and travel agencies."[250] For example, Philippine Airlines' "special services for doctors and nurses," which included hospital placement and "fly now pay later" plans.[251] A Korean travel agent claimed to be able to place physicians in a labor-hungry hospital with a few phone calls.[252] According to a Rockefeller foundation report, from 1950 to 1959, the number of foreign medical graduates in US training programs expanded from 2,072 to 9,457.[253] By 1960, 32% of interns and residents in US training programs were FMGs, and yet 20% of residency positons still remained unfilled.[254] Even elite programs sometimes brought in foreign physicians, with 10% of the interns at Johns Hopkins in the late 1950s hailing from international schools. In the early 1950s, many of these physicians were from Europe, but over the course of the decade, Asian countries became better represented.[255] [256] A 1955 study on physicians in the US on exchange programs, lists 1,229 Europeans and 1,983

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[248] Stevens and Vermuelen, "Foreign-Trained Physicians," 55.

[249] Ibid, 54.

[250] Ibid, 56.

[251] Choy, *Empire of Care*, 75.

[252] Lyons, "Foreign Physicians, Many Unqualified," 1967.

[253] Ludmerer, *Time to Heal*, 185.

[254] Ibid.

[255] Starr, *The Social Transformation,* 360.

[256] James E. McCormack and Arthur Feraru. "Alien Interns and Residents in the United States." *JAMA* 158, no. 15 (August 13, 1955): 1357.

physicians from "the Far, Near, and Middle East."[257] At a time when the restrictive quota system of the 1920s remained mostly in force, exchange visitor programs were one of the only avenues of entry for immigrants from these regions.

Responding to pressure from hospitals claiming an urgent shortage of manpower states and regulatory agencies quietly lowered some of the barriers erected against foreign physicians just a decade ago. In 1950, through a cooperating committee of the AMA and the AAMC, efforts were made to prepare and update a list of foreign medical schools whose education was equivalent enough to that in the US to allow their graduates to enter US internships and residencies. By the mid-1950s, with exchange visitor physicians arriving from 84 different countries, this became increasingly unfeasible.[258] In 1957, these groups established the ECFMG, or the Educational Commission for Foreign Medical graduates in order to handle certifying and credentialing of these physicians. This regulatory agency, which by its own proclamation "assumes a politically neutral stance with respect to the impact of FMGs on the US physician workforce," was tasked with certifying *individual* FMGs to enter the US system by administering examinations and verifying credentials.[259] The ECFMG remains the organization tasked with regulating foreign-educated physician entry into the US system, and has become another avenue for implementing policy regarding this group.[260] Many hospitals were not eager to accept a

[257] McCormack and Feraru, "Alien Interns and Residents," 1358.

[258] McCormack, James A, and Arthur Feraru. "Alien Interns and Residents in the United States, 1955-1956." *JAMA: The Journal of the American Medical Association* 161, no. 4 (May 26, 1956): 322–24.

[259] N. E. Gary, M. M. Sabo, M. L. Shafron, M. K. Wald, M. F. Ben-David, and W. C. Kelly. "Graduates of Foreign Medical Schools: Progression to Certification by the Educational Commission for Foreign Medical Graduates." *Academic Medicine: Journal of the Association of American Medical Colleges* 72, no. 1 (January 1997): 20.

[260] Physicians who graduated from medical schools in all foreign countries except Canada generally have to be ECFMG certified in order to enter GME training in the US. Canadian medical schools, however, are exempt, as they have historically been accredited by the LCME (Liaison Committee on Medical Education) which also accredits US schools. This is a legacy of the inclusion of Canadian medical schools in the Flexner report, and possibly the special interest Rockefeller philanthropy trustees had in Canada its medical education in the early 20th century (see ch. 3).

process which might slow their access to FMG manpower, however, when the Joint Commission for the Accreditation of Hospitals made ECFMG certification of all FMGs a requirement, they had little grounds to object.[261]

Although the law specifically prohibited sponsors from using the exchange visitor program to alleviate labor shortages, the fact that many hospitals did just that became an open secret. Along with recruiting resident physicians, many of these same hospitals used the Exchange Visitor Program to bring in nurses from abroad, particularly the Philippines, which offered a ready supply of nurses trained in a heavily Americanized system.[262] The purposes of the program were generally transparent to participants and administrators alike, as one nurse recalled, "…when you came here you were working as a staff nurse with a stipend. They didn't call it salary because of they call it a salary that means you're a permanent employee…Everybody knew that."[263] Furthermore, a good number of the physicians and nurses who came in under this program either applied for exemptions and remained in the US as immigrants, or returned to the US after having spent some period of time at home.[264] [265] This arrangement, which served the interests of international health workers and "staff hungry hospitals" in their own ways remained mainly unquestioned until the 1960s.[266] As Stevens and Vermulen argue, there were some ideological stakes in how participants and other interested parties chose to view the program throughout the 1950s. The idea of reliance on foreign healthcare workers would be difficult to square with American medicine's self-perception as a model for the word

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[261] Stevens and Vermeulen, "Foreign-Trained Physicians," 34.
[262] Choy, *Empire of Care*, 78.
[263] Ibid., 81.
[264] Ibid., 61-62.
[265] Stevens and Vermeulen, "Foreign-Trained Physicians," 62.
[266] Ibid.

(an attitude that was itself built up in response to an earlier generation of immigrant physicians.) Nor was organized medicine eager to concede that their policies of "professional birth control" and opposition to expanded roles for paraprofessionals were contributing to an unsustainable manpower situation. Likewise, in a broader sense it would mean "the United States would have to cease posing as a donor of foreign aid (through an educational program) and admit it was a recipient of foreign largesse (by importing skilled manpower)."[267] These ideological stakes, combined with the fact that arrangements between hospitals and exchange visitors helped each serve their own needs contributed to an uneasy consensus about FMGs in US hospitals in the 1950s. In the setting of overall prosperity and seemingly limitless growth and public support within medicine, FMGs were able to mask some of the glaring deficiencies of the system, and thus, relative to past and future decades their roles were fairly peripheral to public and professional attention.

STRANGERS AT THE BEDSIDE: IMGS IN THE SETTING OF AN EMBATTLED PROFESSION AND CHANGING VIEWS ON IMMIGRATION

Factors that brought physicians to the US as exchange visitors and immigrants in the 1950s continued unabated into the 1960s and 70s. Over the course of these decades, however, the confluence of interests that kept the role of foreign trained physicians relatively uncontroversial fell out of step. American hospitals remained hungry for house staff as cheap labor to uphold their bottom lines as well as their societal roles as the increasingly technologized epicenters of American medical care. Now over a half century old, the Flexnerian ideology of limiting the number of physicians trained in the US

[267] Stevens and Vermeulen, "Foreign-Trained Physicians," 63.

continued to have force, even in the face of a growing deficit of hospital labor. Both of these views, however, came to be challenged by a new chorus of voices that until that time were not heard very loudly in the relatively insular world of the medical profession. As David Rothman argues in his history of medical decision making, *Strangers at the Bedside*, beginning in the mid-1960s, major changes in American Medicine "have altered almost every aspect of the relationship between doctor and patient—indeed between medicine and society…the discretion that the profession once enjoyed has been increasingly circumscribed, with an almost bewildering number of parties and procedures participating in medical decision making."[268] Medicine, Rothman and his fellow historians argue, entered a period of fundamental instability and change in the 1960s and 70s. The most important aspect of these changes was the increasing involvement of academics, government agencies, and the general public in issues crucial to medicine. American medicine, which had enjoyed an era of prosperity and trust in the period after WW2, had to renegotiate a new social contract in response to critiques by social scientists and ethicists, legal challenges, legislative regulation, and activist patients. Thus, this new wave of debates about foreign trained physicians was no longer contained within medicine itself, but invited increased government and academic input.

The 1960s and 70s, were of course an era of major change in many aspects of American society. Just as the Civil Rights movement began to negotiate a new role for minorities in American culture, profound changes in immigration law began to have surprising and sometimes unsettling effects on immigration patterns. With restrictive ethnic quotas lifted, a new wave of immigrants, many of them middle-class professionals

[268] Rothman, *Strangers at the Bedside* ,3.

from Asia and other non-European nations, began to change and challenge notions of American identity. Once again, as in the 1920s and 30s, Foreign-trained physicians were at the nexus of these two cultural shifts, the changing roles of immigrants and the re-orientation of the role of medicine in American society. Continuing trends that began in the 1950s, and that were enhanced by the 1965 immigration legislation, immigrant physicians were increasingly from non-European countries. Just as American medicine seemingly assimilated the native and foreign born Jews and Italians that posed such a challenge in earlier decades, it came to face a new outsider/insider group of East and South Asians and Middle-Easterners. By the 1970s, FMGs were once again an urgent subject of discussion- with a larger group of interests than ever assessing their competence, claiming they were either essential or detrimental to the US healthcare system, and beginning to talk about issues of "brain drain" and the geopolitical context of this migration. Once again images of the good and bad immigrant, reconstructed in the changing social context of this era came into play. The period between 1960 and 1980 also saw a revival of the debate about physician supply as well as unprecedented federal intervention on this issue. This section will describe some of the significance of these seemingly disparate cultural shifts of the 1960s and discuss how foreign-trained physicians once again became politically controversial, as debates about them implicated fundamental issues within the US healthcare system and an increasingly diversifying society.

The Crisis of Medicine

As Thomas R. Cole, a medical humanist reflecting the 60s and 70s put it, "sometime in the mid-1960s, the bloom began to fall from the rose of modern medicine."[269] Much like the 1930s, the threat to medicine was perceived as more than one of finances but also one of autonomy and authority. Over the course of these decades, medicine faced questions both from without and from within. Sociologist-historian Paul Starr marks the year 1969 as the year popular and political discourses began to speak of a "crisis in healthcare." These developments caught many physicians off guard, in a reversal from rhetoric only a decade old, "once a hero, the doctor ha[d] now become a villain…while Americans express[ed] confidence in their own personal physicians, they [were] more hostile to doctors as a class."[270] Historians Paul Starr, Kenneth Ludmerer, and David Rothman each focus on different elements of this perceived crisis and how these elements came together to question the roles of medicine and physicians in American society. Rothman focuses his analysis on revelations of research abuses by leading American physician-scientists, which inspired greater scrutiny of physician motives by an increasingly disillusioned and activist public and legal regulation of some aspects of medical decision making. As Ludmerer chronicles, this disillusionment extended to medicine's younger generation, who increasingly eschewed organized medicine and engaged in student activism. Starr on the other hand, focuses on another aspect of the crisis of medicine, the controversy over the increasing federal role in the financing and availability of medical care.

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[269] Thomas R. Cole, "Toward a Humanist Bioethics: Commentary on Churchill and Andre," in *Philosophy of Medicine and Bioethics: A Twenty-Year Retrospective and Critical Appraisal*, Ronald A. Carson and Chester R. Burns eds. (Dordrecht, the Netherlands: Kluwer Academic Publishing, 1997), 173.

[270] Paul Starr, *The Social Transformation*, 393.

Since the 1930s, the AMA and other conservative physician groups had been largely successful at preventing any significant federal and state participation in health insurance or health provision. Through intensively financed PR campaigns, physician groups were often successful at re-orienting the issues of these proposals, drawing on fears of "socialized medicine" and its Cold War association with Communism.[271] Post war negotiations between legislators and organized medicine usually looked like unqualified victories for the later. In each case, rather than accept regulation, physician groups were successful in getting funding and resources from the government while largely retaining autonomy in making use of these resources. The post-war Hill-Burton Act was a good example of this pattern. Medicare, a health insurance plan for the elderly first proposed in the 1950s and heavily supported by the Kennedy and Johnson administrations, initially followed the same pattern. Although the AMA strongly militated against a plan they claimed would "put the government smack into the hospital," Medicare and with it, what was to become Medicaid passed in 1965.[272]

One compromise in the bill, however, seemingly turned the legislation from an onus into a bonanza for physicians and hospitals. Rather than have the government set reimbursement rates, these were left to doctors and hospitals.[273] The way Medicare was structured "denied the government any leverage to control costs," initially a winning feature for doctors, it began to work against them as uncontrolled fees brought down regulation from strapped federal and private insurers.[274] Costs of healthcare had risen alarmingly by the end of the decade and hinted at "parochial self-interest that lay just

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[271] This included an editorial in JAMA by J. Edgar Hoover comparting communism to metastatic cancer.

[272] Julian E. Zelizer, "How Medicare Was Made." *The New Yorker*, February 15, 2015. http://www.newyorker.com/news/news-desk/medicare-made.

[273] Zelizer, no pg.

[274] Starr, *The Social Transformation*, 383.

beneath the surface of medicine's official proclamations of patient-centered professionalism."[275] "The cost question turned the spotlight on other deficiencies of the system," [276] and Americans began to opine that they were paying more money for worse health outcomes than many of their first world compatriots.

Medicare/Medicaid and the Role of House Staff

Medicaid and particularly Medicare had profound implications for the academic and community medical centers already heavily dependent on service by interns and residents. With NIH funding for research diminishing in the late 1960s, these federal health insurance programs became the new revenue stream for medical schools and community hospitals as "their fate became allied to that of the healthcare delivery system."[277] Medical centers "began receiving payment for virtually every service they had formerly provided free or below cost to many indigent patients."[278] Initially hospitals feared that the transformation of charity into paying patients would curtail their use of house staff to provide them services. However, negotiations with Medicare and Medicaid administrators resulted in an understanding that residents could play major roles in caring for these patients. More than ever before, the service contributions of interns and residents, already crucial to the functioning of many hospitals, became increasingly remunerative. Millions of Americans suddenly had much greater access to the healthcare

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[275] David Barnard, "Generations Do Not Write Books: A Sociological Autobiography of My Medical Humanities Career." *Medical Humanities Review* 15, no. 2 (2001): 24.

[276] Starr, *The Social Transformation,* 382.

[277] Ludmerer, *Time to Heal*, 228.

[278] Ludmerer, *Time to Heal*, 222.

system. Between 1965 and 1980, hospital admissions grew by 50%, particularly of older, sicker Medicare patients.[279]

These changes once again highlighted ambiguities in the roles of house staff, questioning their dual roles as learners and employees, and became particularly acute for an ever growing contingent of Foreign Medical Graduates in Graduate Medical Education. The latter half of the 1960s saw a rise in the number of FMGs in American hospitals of all sizes as well as both in hospitals affiliated and not affiliated with medical schools. The percent of FMGs in US hospital residencies rose from 24% in 1963-64 to 33% in 1970-71.[280] By the late 1970s, FMGs formed the majority of the residents in 23% of American hospitals with residency programs.[281] This period also saw an overall rise in house staff positions and very little change in unfilled positions, which remained steady at around 5,000 from 1965 to 1971.[282] However, breaking down hospitals by size and affiliation revealed a stratification of US and Foreign trained medical graduates. Foreign-trained doctors made up only 14% of the residents of large hospitals affiliated with a medical school but 55% of the residents at small non-affiliated hospitals in 1960.[283] Thus with the advent of Medicare and Medicaid, hospitals became even more reliant on interns and residents. Both for American medical graduates in preferred academic residency spots as well as for FMGs in less desirable community hospital training positions, their roles as the cheap labor that supported the hospital threatened to overshadow the educational goals of their training.

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279 Ludmerer, *Time to Heal*, 223.

280 Stevens and Vermeulen, "Foreign-Trained Physicians," 112.

281 P O Way, L E Jensen, and L J Goodman. "Foreign Medical Graduates and the Issue of Substantial Disruption of Medical Services." *The New England Journal of Medicine* 299, no. 14 (October 5, 1978): 745.

282 Stevens and Vermeulen, "Foreign-Trained Physicians," 110-111.

283 Stevens and Vermeulen, "Foreign-Trained Physicians," 116.

As Kenneth Ludmerer points out, the crisis of medicine in the 1960s and 1970s was as much internal as external to the profession. Although not nearly as militant as their undergraduate compatriots, medical students and residents became increasingly aware of Civil Rights, the Vietnam war, and other pressing social issues of their times.[284] As one contemporary medical educator summarized it, "there appears to be much more unrest among medical students today than in previous decades." He attributes this unrest both to "student involvement in the social problems of mankind," and the "dehumanizing experience" of being both a medical trainee and a patient.[285] Medical trainees became concerned that their teachers and administrators were out of touch with both the major social issues medicine was implicated in as well as the increasingly demanding nature of a more technologized, complex hospital environment.[286] One reflection of this generation gap in medicine was decreasing participation in organized medicine. In 1971, for the first time in a half-century, AMA membership dropped below 51% of physicians.[287]

The increased burden of clinical care in medical school-affiliated and community hospitals alike became apparent nationwide through attempts at organization and protest by house staff. The Committee of Interns and Residents, founded in 1958, became one of the major umbrella organizations for house staff unionization and began to see more action in the early 1970s.[288] Strikes over low pay, grueling call schedules, and 100 hour work weeks occurred at hospitals across the country.[289] According to Kenneth Ludmerer, "in general house staff associations tended to be more organized and militant

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284 Ludmerer, *Time to Heal*, 238-242.
285 McGovern and Burns, *Humanism in Medicine*, 90.
286 Ludmerer, *Time to Heal*, 247.
287 Starr, *The Social Transformation*, 398.
288 Ludmerer, *Time to Heal*, 245.
289 Ludmerer, *Time to Heal*, 247.

at hospitals with close affiliations with a medical school, which suggested to some that the unionization movement was more pronounced in situation where house officers felt they were not receiving much faculty attention or good teaching.'"[290] Another factor in this however, could have been that these groups of house staff were predominantly American-educated and felt more secure in demanding their rights.

Stevens and Vermeulen, writing in 1972, found evidence to suggest that a definite stratification existed between the types of residency programs that were staffed primarily by US and Foreign medical graduates. This was a division that was to persist into later decades: Abraham Verghese, for example, described it as the dichotomy of "Mayflower," and "Ellis Island" residency programs—rarely officially acknowledged or defined, but incontrovertably apparent.[291] In fact, the presence or absence of FMGs became a proxy for competitiveness and status among American residency programs. As Robert C. Derbyshire remarked in a 1975 JAMA article, when new residency programs are first opened they are primarily staffed by FMGs, which are gradually replaced by US graduates as the program becomes established. He recalls how one residency director told him "with an air of pride…'We haven't had a foreign graduate on our house staff for four years.'"[292] Current evidence implied that overall, FMG-dependent residencies were particularly service-heavy, and this emphasis on the employee aspect of residency could potentially compromise the education of house staff. This included statistical studies that demonstrated that FMGs made up the greatest percentage of trainees in less prestigious, traditionally service heavy community-based programs. Likewise, Stevens and Vermulen

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290 Ludmerer, *Time to Heal*, 245.

291 "The Cowpath to America." *The New Yorker*. June 23, 1997. Accessed April 9, 2015. http://www.newyorker.com/magazine/1997/06/23/the-cowpath-to-america.

292 R C Derbyshire, "Warm Bodies in White Coats." *JAMA: The Journal of the American Medical Association* 232, no. 10 (June 9, 1975): 1035.

argue based on contemporary studies, "graduates of medical schools from developed countries abroad gravitate toward the most desirable training positions in the United States, while the graduates from schools in less developed countries tend to be 'out in the sticks.'"[293] Surveys of FMGs revealed that only 14% were satisfied with the level of training at their residency programs and 27% felt that they "received minimal if any supervision," in their hospital roles.[294]

More so than in the 1950s, this service role of FMGs in the US healthcare system was widely known or suspected, yet rarely acknowledged. Although a few voices, including Stevens and Vermeulen in a congressional report, drew attention to the ethical implications of this seeming abuse of educational exchange, the predominant attitude toward the issue among multiple stakeholders including hospitals, organized medicine, legislators, and even sometimes FMGs themselves was one of foregrounding present needs over ethical and structural questions. A 1965 congressional panel found, though not in so many words, that the US healthcare system was essentially dependent on FMGs. The National Committee of Health Manpower, appointed by the Johnson administration in 1967 estimated that it would cost between 855- and 925 million dollars to replace the labor FMGs had performed between 1961 and 1965.[295] Legislators at all levels, not to mention the American Hospital Association and individual hospitals were not willing to address the difficult questions this issue raised, instead focusing on smaller-scale, solutions such as advising the ECFMG to enact more restrictive exam standards.

293 Stevens and Vermeulen, 43.
294 Ibid, 47.
295 Ibid. 68.

STRANGERS IN A STRANGE LAND: FMGS IN A CHANGING HEALTHCARE SYSTEM

One of David Rothman's key arguments about the crucial cultural shift in the role of medicine in American society in the 1960s and 70s centered on what he called the emergence of the "doctor as stranger." In a broad sense, Rothman argues, physicians and patients came to feel alienated from each other, struggling with cultural and communication barriers that hadn't previously been so noticeable. This, he felt was one of the root causes of the crisis of medicine in the 1960s and 70s. Although he does not specifically discuss the role of FMGs, his analysis is helpful in understanding the cultural moment at which FMGs became controversial. He argues, "practically every development in medicine in the post-World War II period distanced physician and the hospital from the patient and the community."[296] An increasingly complex, technologized, hospital-based system "almost guarantees that at a time of crisis patients will be treated by strangers in a strange environment."[297] Before WW2, Rothman explains, most Americans experienced medical care as an intimate interaction with a physician who was a community member, often a person of the same ethnicity or culture, known socially as well as professionally to the family. When a patient went to hospital, he or she was in more familiar surroundings, with ethnic institutions such as Jewish and Catholic hospitals providing for patients' social and cultural needs.[298] With fewer technologies readily available, diagnosis was often via the case history, gathered via prolonged patient-physician conversations.[299] Likewise, treatment "was essentially composed of the human touch."[300]

The disappearance of the house call around 1945 was the first sign of physicians and patients moving apart, followed by the steadily growing predominance of specialists over general

296 Rothman, *Strangers at the Bedside,* 127.
297 Ibid., 128.
298 Ibid., 123.
299 Ibid., 117.
300 Ibid., 128.

practitioners.[301] Rothman argues that a more open, meritocratic system of medical training, encouraged by greater amounts of research and hospital funding available after WW2 had the unintended consequence of eroding what was special about the sectarian hospital, as well as broke down the barriers that kept ethnically congruent physicians in their communities.[302] As discussed earlier, professional restrictions resulted in admission to American medical schools becoming increasingly expensive, labor intensive, and competitive. Not only did this limit the number of low income and minority medical students, but it also served to isolate the medical students that were able to get in from the society around them. Spending as much as 15 years as students in a "segregated medical world," most of it in an increasingly demanding technical environment, left physicians with little time and energy for their community roles.[303] The main rift, Rothman argues, at least in the public perception, between American society and its physicians, was one of values. This same era saw the birth of the medical humanities and bioethics movements, focused on returning a sense of humanity and values to medical education.[304]

In a setting where all doctors to some extent became strangers, both the public and the profession became more aware of the new demographics of American physicians. By the 1960s, nearly 1 in 4 physicians a patient encountered came from a different culture and perhaps spoke with an accent. Many of these physicians also looked racially different. Medicine became a multicultural entity somewhat ahead of the rest of American society, and the transition wasn't always smooth. It was not just the doctors who changed in the post WW2 era, however, as Medicare and Medicaid, as well as demographic transitions within major American cities brought a whole new group of patients into the hospital setting. These reforms, intended to de-stratify the way the poor and the rich got care, had complex results. Poor Americans had often relied on

301 Ibid.
302 Ibid, 130.
303 Ibid., 136-137.
304 Ibid., 141-142.

hospital dispensaries, where they often got care from medical trainees, while the middle class primarily made use of private physicians. As explained above, Medicare and Medicaid greatly increased the workload of the American healthcare system, without changing its hospital-based, acute care focus. These developments created an odd hybrid of the two systems, extending the roles of house staff to caring for insured and private patients as well. Many of these new patients, among them individuals from low income and minority households, disproportionately sought care at the hospitals Verghese referred to as "Ellis Island" programs. Many of the institutions that cared for these patients, mostly community hospitals as well as urban campuses of university – affiliated institutions, relied disproportionately on overworked house staff, many of them FMGs. The 1960s and 70s saw "the economic and social decline that occurred in many older industrial cities."[305] Beginning in the WW2 years, Blacks, and later Puerto Ricans and Mexicans moved to industrial Northern cities in hopes of finding jobs and a better life. However, as these groups arrived, "many businesses and much of the white middle class left for the suburbs."[306] Traditional ethnic enclaves in American cities dissipated, replaced by a new set of often disenfranchised newcomers. As the "tax base eroded, unemployment and poverty rose, essential municipal services sometimes went unprovided."[307] University medical centers and community hospitals often had fraught relationships with their neighborhoods and while some community hospitals moved their staff and facilities to the suburbs, some also stayed the course. As insured suburbanites sought care in safer, more comfortable areas closer to home, the Medicaid-funded and uninsured patients who lived in catchment areas of academic medical centers began to make up a larger proportion of their patients. As Ludmerer describes it, in this era, "virtually no one was left to care for the inhabitants of the inner cities but the physicians and staffs of teaching hospitals." These new developments set up a relationship that has become a fixture of American

305 Ludmerer, *Time to Heal*, 260.
306 Ibid.
307 Ibid., 261.

medicine: with FMGs, often the most vulnerable group of physicians, caring for America's most vulnerable, and reputedly troublesome, groups of patients.

Organized Medicine on the Defensive

The FMG question, when examined deeply, made obvious the cobbled together nature of medical workforce solutions in the US and on another level, reflected the inherent instability of a rapidly changing healthcare system. Just as it did in the 1930s and 40s, organized medicine attempted to respond by tightening control over its own house. As in the past, the primary way to do that was to restrict physician supply through the educational pipeline. However, by the 1960s and 70s the growing role of "outsiders" in medicine resulted in a more complex debate. Although the old wisdom of strictly limiting the number of doctors still held sway for many medical educators and leaders of organized medicine, struggling hospitals felt very differently. Even before the more radical intervention of Medicare/Medicaid, however, the federal government became involved in what was traditionally viewed as organized medicine's domain, with incentives to increase the number of medical school places. In 1959, the surgeon general's consultant group on medical education released a report titled *Physicians for a Growing America*, eventually known as the Bane report, which "predicted a shortage of approximately 40,000 physicians by 1975."[308] [309] The report concluded that "if we are to maintain a ratio of 141 physicians per 100,000 population this will not suffice."[310] Thus, although this group challenged the prevailing status quo, its estimates were still extremely conservative, mentioning the influx of FMGs only briefly, and seeking only to maintain physician/population ratio, rather than reassess the numbers of health professionals that would be needed for the increasingly technology-intensive, specialized healthcare environment. In response, beginning in the early 1960s, the

[308] Blumenthal, "New Steam for an Old Cauldron," 1781.

[309] C. H. Ruhe, "Present Projections of Physician Production," *JAMA* 198, no. 10 (December 5, 1966): 1094–1100.

[310] U.S. Department of Health Education and Welfare, "Physicians for a Growing America." *Archive.org*, October 1959. https://archive.org/stream/physiciansforagr022196mbp/physiciansforagr022196mbp_djvu.txt.

Kennedy and Johnson administrations pushed through legislation that effectively subsidized medical school places and resulted in double the annual number of US medical school graduates by 1985.[311]

As contemporary statistics showed, this rapid growth in American medical school graduates along with the expanding number of FMGs coming to the US remained insufficient to fill the US hospital system's insatiable demand for house staff—many residency positions went unfilled into the 1970s. These facts, however, did little to stem anxieties, particularly over the impact of FMGs. Perhaps one of the biggest challenges of these transitional decades for organized medicine was these groups' loss of control over many issues in healthcare that had previously been under their purview. Namely this had been the ability for medicine to keep its own house in terms of ethics, decision-making, and education. As an irate AMA president exclaimed: "Passengers who insist on flying the airplane are called hijackers!"[312] Like the increasingly activist federal government, a newly critical cadre of academics, and a disillusioned group of medical trainees, Foreign Medical Graduates were perceived as a problem of control. The increasing numbers of these physicians in American hospitals symbolized one of the many ways organized medicine was losing its previous authority and autonomy in the healthcare system. Throughout the 1960s and especially the 1970s the medical establishment responded to FMGs with a tone of growing suspicion. Overall, during this period, the medical establishment came to see FMGs as a problem, rather than as a group of fellow physicians with special needs or concerns. Multiple publications of the period began to cite statistics that FMG residency applicants were beginning to outnumber domestic graduates (to some extent this was true in the early 1970s, depending on how one did the statistics).[313] [314] [315] Other publications

[311] Blumenthal, David. "New Steam from an Old Cauldron," 1781.

[312] Starr, *The Social Transformation,* 408.

[313] Lyons, "Foreign Physicians, Many Unqualified," September 29, 1967.

[314] Harold Margulies, "Foreign Medical Graduates: An Unsolved Crisis in U.S. Hospitals," *Hospital Progress* 49, no. 6 (June 1968): 70.

focused on assessing the competence of these foreign graduates, often finding them lacking in some way. Many of these commentators made reference to the fact that the majority among this new group of FMGs were from Asian and "developing" countries, associating these graduates in particular with lower academic and clinical standards. Some of these discourses came to be reflected in more mainstream public debates as well.

Post 1965: The Backlash against FMGs

As described earlier, shifts in the demographics of the medical profession prefigured the national trends in professional immigration. By the late 50s more exchange visitor physicians were arriving from Asia and the Middle East than from Europe. Additionally, as a result of the 1965 immigration legislation, an increasing number of physicians were able to come to the US as immigrants. Debates about foreign medical graduates both within medicine and in the public sphere drew on larger discourses about immigration. Questions of the public good and the overall dynamism of the medical environment in this period made these arguments all the more keen and raised the stakes. Within medicine as well as the ever widening circles of bureaucrats and academics who took an interest in its political workings, debates seemed to crystalize around three topics: the needs of the US healthcare system, the competence of the Foreign Medical graduates to practice in the US, and a growing concern about "brain drain" from poor to rich nations.

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315 K. M. Tan, "Foreign Medical Graduate Performance--a Review." *Medical Care* 15, no. 10 (October 1977): 822-823.

Multiple accounts focused on the sheer numbers of FMGs, and statistics that seemed to show that foreign entrants overwhelmed new American graduates were citied over and over again in both popular and professional pieces. [316] [317] [318] [319] In 1971 alone, 10,540 immigrant and exchange visitor physicians entered the country, while American medical schools graduated only 8,874.[320] [321] In that same year the major source countries for foreign-educated physicians were India, with 1,513 entrants, the Philippines with 1,365, and Korea, with 1,003 (Canada was 4th, with 785). Many contemporary accounts focused on where these physicians were coming from, emphasizing that the majority hailed from "under developed," "3rd world" or "poor" nations," which were reflexively associated with poor educational quality. In a controversial NEJM article, Weiss and colleagues make sure to note that 70% of physicians entering the US were from Asia, predominantly the Philippines.[322] Likewise, a 1967 article in the New York times notes that in addition to the more familiar European FMG's "a much larger number enter from such underdeveloped nations as India, Iran and the Dominican republic, countries with lower standards of healthcare and a doctor shortage of their own and these physicians may have only the sketchiest knowledge of both English and medicine."[323] In the 1950s and 60s, when a more sizable percentage of FMGs were European, the topic of FMGs in the US healthcare system was of relatively niche interest. In the late 60s and into the

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316 Margulies, "Foreign Medical Graduates: An Unsolved Crisis," 70.

317 Harold Margulies, "The Government and Graduate Medical Education." *Bulletin of the New York Academy of Medicine* 50, no. 11 (December 1974): 1212.

318 R J Weiss,, J C Kleinman, U C Brandt, and D S Felsenthal. "The Effect of Importing Physicians--Return to a Pre-Flexnerian Standard." *The New England Journal of Medicine* 290, no. 26 (June 27, 1974): 1453.

319 Lyons, "Foreign Physicians, Many Unqualified,"1967.

320 Stevens and Vermeulen, "Foreign-Trained Physicians."

321 As California physician Kong Meng Tan argued, these numbers may have been exaggerated. Particularly in the few years after the 1965 immigration changes, some of the figures about foreign physicians included "double counting" of exchange visitor physicians who had previously entered to country converting to immigrant status.

322 Weiss et al, "Pre-Flexnerian Standard," 1974.

323 Lyons,"Foreign Physicians, Many Unqualified," 1967.

1970s, the apparent racial and cultural differences of this new group of FMGs along with their growing numbers drew attention to them like never before.

Clearly at stake in these discourses of suspicion was the authority of organized medicine. Marguiles expressed his concern about the competence of foreign medical graduates in several articles in the medical literature throughout the late 60s and early 70s. For him as for others, questions of competence were explicitly linked with the developing world origins of these physicians. As he argued in a 1974, "An individual from Lucknow, Chengmai, Shiraz—or wherever, who has after multiple, (or no) failures, passed the examination of the ECFMG and spent three of four years in several hospitals which the medical profession has accredited," may look the same on paper as "a specialist physician who went through the same program of hospital training after graduation from Columbia, Cornell, the University of Kansas, or the University of California." Echoing sentiments in the 1920s and 30s about admitting the children of immigrants into medical schools, he continues, "in a technical sense you say they are the same in a professional sense you know they are not," he concludes, "The differences are not confined to linguistic and cultural variance, they are associated with a lifetime of education which culminates in medical school and what follows."[324]

American organized medicine perceived its own stakes in this debate to be high. As Thomas Dublin argued in a 1972 New England Journal of Medicine article, "attributing equivalency of medical education obtained in any medical school throughout the world with a similar education acquired in the United States threatens the maintenance of high standards of medical practice in this country."[325] One of the major

[324] Marguiles, "The Government and Graduate Medical Education," 1974, 1213.
[325] Dublin, "The Migration of Physicians to the United States," 875.

roles, and claims to authority of organized medicine groups like the AMA and the AAMC was the regulation of medical education. Drawing on the ideologies of the Flexnerian era, these groups claimed to control quality and restrict entry into the profession in the name of the public good. A growing number of physicians apparently circumventing these controls was a direct threat to this group's authority. Demonstrating that these physicians were not of equivalent quality to American graduates thus became imperative to the maintenance of deeply held beliefs among American medicine's mainstream. With American legislators deeply concerned about a shortage of medical manpower, some saw importing doctors as a legitimate and quick solution. Health Education and Welfare Secretary Caspar Weinberger argued in 1973, "I know that a great many foreign trained physicians are being used to fill the healthcare needs of this country and that I don't think in itself is necessarily a bad thing…They come here, apply for credentials, and when they are found qualified…they practice. The most important thing to consider here is the satisfaction of the need for medical personnel."[326] Given this perceived crisis, American organized medicine had three choices, all of which stirred up deep-seated ideological aversions: expanding American medical education, acquiescing to the use of para-professional health providers like Nurse Practitioners, or accepting and encouraging the immigration of "third world" physicians. As discussed earlier, with the results of the Bane report, organized medicine acquiesced to increasing medical school enrollment, but this intervention would take time to actually increase physician supply. Importing physicians appeared to be the fastest solution In the face of a perceived crisis

[326] Weiss et al. "Flexnerian Standard," 1453.

of medical manpower. Thus physicians concerned about the "unsolved crisis" of FMGs made several attempts to quantify their strongly felt aversions to this group.

The legacy of an earlier generation of medical protectionists, who sought to convince their fellow physicians and the American public of the inferiority of foreign physicians once again came into play. This time, however, the task was made easier by a general unfamiliarity with the places and medical education systems these physicians came from. Whereas in the 1940s many American physicians were still familiar with the European medical educational system, only a few Americans knew anything about medical education in India, Iran, or Taiwan. Although larger issues of race and immigration were at play, many who made these claims, often representing organized medicine, framed these issues in terms of physician competence and public safety. Beginning in the late 1960s, several studies appeared in major medical journals, purporting to show that "thousands of FMGs in US hospitals are not providing the quality of patient care we expect from our own graduates."[327] To borrow Rothman's phrase, FMGs exemplified the idea of "strangers at the bedside," and by the 1970s the American public, legislators and the American Medical profession were seeing these strangers as increasingly distant, inscrutable, and threatening.

Perhaps the two most influential and controversial articles on FMGs of this period appeared a week apart in June of 1974 in the *New England Journal of Medicine*. Both articles were authored by Harvard working groups led by Robert J. Weiss. The first, entitled "Foreign Medical Graduates and the Medical Underground," heralded concern about FMGs on two fronts, reaffirming statistics about low exam pass rates among this

[327] Marguiles, "Foreign Medical Graduates: An Unsolved Crisis," 1968, 714.

group as well as alleging that despite failing to pass the examination, over 10,000 Foreign Medical Graduates were working in American hospitals, nursing homes and state institutions as unlicensed physicians. Researchers administered a questionnaire to ECFMG exam takers asking about their current employment. From their survey results they concluded that "large number of FMGs are functioning in a medical underground delivering patient care in an unsupervised and unregulated fashion."[328] Furthermore, they note with alarm, those FMGs employed in the healthcare field, actually did more poorly on exams than those who were not. Likewise, age and experience often correlated inversely with exam performance. As in many articles of this period, the third world origins of many in this group were noted and the researchers' results were said to "raise serious questions concerning… the influx of FMG's on quality of care, and the need for tighter control of medical practice by not fully licensed physicians."[329]

The second article made broader statements about the presumed "quality of the product" of foreign medical schools.[330] Concerned that the increasing presence of FMGs in the US healthcare system would herald a return to a "Pre-Flexnerian" standard, the authors harken to powerful shared ideologies of the American medical profession. Many of these arguments also recalled rhetoric of the 1920 and 30s. The influx of FMGs undermined the careful controls the US medical establishment had put on physician quality for the past 60 years, they argued. As compared to "minimal admission standards applied in many developing nations," American medical schools had been carefully selecting eligible candidates in the public interest since the Flexner reforms of 1910. This

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[328] R.J. Weiss, J. C. Kleinman, U. C. Brandt, J. J. Feldman, and A. C. McGuinness. "Foreign Medical Graduates and the Medical Underground." *The New England Journal of Medicine* 290, no. 25 (June 20, 1974): 1408–13.

[329] Weiss et al, "Medical Underground," 1413.

[330] Weiss, "Flexnerian Standard," 1453.

difference in standards, they argue, is readily evidenced by the fact that "many United States College students who fail to gain admission at an American medical school are easily admitted to certain medical schools in Mexico and the Philippines."[331] The "changing composition of FMGs," in other words the increasing numbers of Asians and others from the developing world, made these quality questions and other aspects of the FMG "problem" urgent. [332] Though the unlicensed FMGs dealt with in their last article are particularly "dangerous," they conclude, even "the best of FMGs," who pass the ECFMG examination and complete an American residency are cause for concern, as they show lower licensing rates than US graduates.[333]

These articles elicited attention from the popular press and from fellow academics. A group of Yale researchers, for example, challenged Weiss's group's conclusions as alarmist, unfounded and politically motivated, arguing that their data was just too faulty to make far reaching conclusions about a shady "medical underground." With a touch of glibness, they conclude that the influence of such a flawed study had more to do with politics than any facts it may reveal: "Any data which apparently supports a policy of restriction of entry for FMGs will be enthusiastically embraced by planners, and may tend to be regarded far less critically by investigators in 1974 than it would have ten years or even five years ago. Such is a familiar human inclination."[334]

On another level, however, the stakes of these portrayals implicated a separate but equally powerful set of discourses. As Asian American studies and immigration scholars

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[331] Weiss, "Flexnerian Standard," 1454.

[332] Weiss, "Flexnerian Standard," 1454.

[333] Weiss, "Flexnerian Standard," 1455.

[334] Rosemary A. Stevens, Louis Wolf Goodman, and Stephen S. Mick. "The 'Medical Underground': Some Thoughts and a Reply." *Medical Care* 13, no. 5 (May 1, 1975): 444.

have contended, the period after the 1965 immigration reforms challenged the American mainstream to reconsider issues of national identity. Images of the good and bad migrant as constructed within discourses about FMGs revealed some of the larger ideological stakes of this debate over a changing America.

NATIONAL DEBATES: IMMIGRATION, CIVIL RIGHTS, AND AMERICAN HEGEMONY

Like in the 1930s, discourses that implicated the competence of foreign trained physicians were not isolated from the larger political context. 1965 marked a radical change in what many had come to believe was discriminatory immigration law. One of the unexpected consequences of revising this law, however, was a new wave of immigration radically different from those the US had experienced before. The overall ethnic make-up these new immigrants matched that of the physicians among them, with many from Asia and other "developing" countries. As scholars in Asian-American studies have pointed out, this new group of immigrants engendered perennial questions of assimilation and identity as well as new socio-economic and symbolic tensions within American society.

The social agitation that was beginning to have profound effects on the US healthcare system as well as on the medical profession also contributed to profound changes in ideas about immigration. Until 1965, the restrictive national origins quota system remained national policy. Throughout the 1960s, however, American legislators became more keenly aware of the discriminatory nature of American immigration policies and their troubling implications for domestic and foreign policy. As American legislators became increasingly aware of decolonization throughout the world, this too added to the Cold War context of these arguments. Immigration scholar Cheryl Shanks

describes the fundamental legislative conflict over immigration in this era as a division between "isolationists," and "internationalists."[335] Both sides were fighting the Cold War in their own ways. While isolationists remained suspicious of the potential corrupting effects of immigrants (some of which were bound to be "subversives") especially from unfamiliar places such as China, the Philippines, and India on American employment, politics, and identity, internationalists saw openness toward these new nations as essential armament in the Cold War struggle. Open immigration, internationalists argued, had enormous propaganda value in contrast to the repressive measures of communist states. Conversely, they argued, discriminatory immigration policies fed the communist propaganda machine against the US.[336] This global public relations battle, internationalists argued, was crucial: "during these times, when we are striving to win over and hold in our camp the peoples of the uncommitted and underdeveloped areas of the world, this problem assumes larger proportions. For these are the very people we are slapping in the face with our national origins selections."[337] Towards the mid-1960s advocates for reform made an explicit connection between immigration reform and civil rights. Senator Hiram Fong of Hawaii argued passionately: "at home we have wiped out racial barriers…' yet "we have erected racial barriers that deny equal dignity and respect to more than one-half of the world's population." The message that a discriminatory immigration policy sent to minority Americans he argued, was one that denied their own worth as citizens.[338]

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[335] Cheryl Lynne Shanks, *Immigration and the Politics of American Sovereignty, 1890-1990*. (Ann Arbor, MI: University of Michigan Press 2001), 184.

[336] Ibid., 155.

[337] Ibid., 164.

[338] King, 244-245.

At the time it was passed, the 1965 Immigration and Naturalization act was seen to have primarily symbolic value. As President Lyndon B. Johnson, a heavy supporter of reform remarked, the act "is not a revolutionary bill. It does not affect the lives of millions….It will not reshape the structure of our daily lives or add importantly to either our wealth or our power." [339] In retrospect, he was dramatically wrong on all counts. The 1965 immigration act had profound demographic and social repercussions for American society. The act opened immigration from all nations, setting quotas by hemisphere with a 20,000 annual cap per individual country. First preference was given to family reunification, allowing first degree relatives of American permanent residents to enter outside of quota totals.[340] Another category was reserved for the preferential entry of skilled laborers and professionals. Not long after the act's passage, its effects became apparent: a major increase in immigration from Asian countries, and a growing predominance of educated, professional immigrants. [341] More than 3.5 million immigrants from countries including China, Taiwan, India, the Philippines, and Korea entered the United States between 1965 and 1980.[342] Less than 1% of the American population in 1965, Asians made up 5.8% of the US in 2012.[343] By the 1970s, Asian immigrants were becoming an increasingly visible presence in large metropolitain areas on the West Coast and in traditional immigrant centers such as New Jersey.[344]

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[339] History.com Staff, "U.S. Immigration Since 1965," History.com, accessed 11/04/2016, http://www.history.com/topics/us-immigration-since-1965.

[340] This preference was a concession to opponents of reform, instituting a more "modern" way to keep a vestige of the quota system- so that new immigrants looked more like those already present in the US.

[341] "The Rise of Asian Americans." *Pew Research Center's Social & Demographic Trends Project*. Accessed March 23, 2015. http://www.pewsocialtrends.org/2012/06/19/the-rise-of-asian-americans/.

[342] Ronald Takaki, *Strangers from a Different Shore: A History of Asian Americans, Updated and Revised Edition* (Boston, MA: Little, Brown and Company, 1998), 420.

[343] Pew, no pg.

[344] Pew, no pg.

This new and in some ways unprecedented diversity of immigrants conjured complex responses within mainstream American culture, renegotiating tropes of "good" and "bad" immigrants. These images, incubated in broader culture had an influence on the professional discourse about the role these immigrants played within American medicine. As historian of the Asian-American experience Ronald Takaki describes, the rapid arrival of these immigrants was often bewildering to the American mainstream. Seemingly overnight, neighborhoods like Los Angeles's Koreatown and New York's "Little India" sprung up. Los Angeles's Monterey Park neighborhood went from being a typical, predominantly white suburb in 1960 to the "Chinese Beverly Hills" in 1988, with a 50% Asian population.[345] The residents were often described as confusing and foreign. Old stereotypes of the mysterious inscrutable Oriental were being challenged in this period, but remained in the cultural background. Although these immigrants had very high naturalization rates, Native-born Americans often let them know that they did not view them as fellow Americans.[346] As a piece of graffiti on a Monterey Park gas station read, "Will the last American in Monterey Park Please bring the flag."[347] More often, however, the lack of acceptance was more subtle, for example, the word "American" being used when the context clearly referred to "white" or "non-Asian." The message was that this group would not and could not assimilate. Another pervasive "bad migrant" trope was almost perennial, that this new group was under-selling and outcompeting Americans for jobs. For Vietnamese shrimpers on the gulf coast, this meant threats from the Ku Klux Klan.[348] However, as many of these immigrants were professionals, this

[345] Takaki, *Stangers*, 425.
[346] Ibid, 6.
[347] Ibid, 425.
[348] Takaki, *Strangers From a Different Shore*, 454.

often took the form of discriminatory exam, licensing, and promotion practices in the professions such as pharmacy, engineering and medicine.

As Cheryl Shanks argues, immigration policy "raises questions of identity and obligation, so debates about immigration tend to involve the philosophical questions of duty and obligation."[349] Second preference was given to immigrants with professional and occupational skills. As Congressman Richard Schweiker argued in the lead up to the Act's passage, "let us fashion a new law which eliminates discrimination on the basis of national origin and asks only of a man what he can contribute to the American civilization of 1965."[350] This rhetoric helped re-define notions of the "good" immigrant, placing an emphasis on social and economic utility, rather than race per say. As discussed previously, advocates for immigrants in the 1930s and 40s, particularly immigrant physicians, emphasized their willingness to adopt American values and lifeways. Not only were these immigrants economically useful, they argued, they were culturally assimilable. The subtle message in the 1965 legislation was that productivity became the standard for assimilability. Along with the great principled arguments that connected immigration reform to Civil Rights and democratic ideals, some supporters of reform saw changes in immigration as essential for economic reasons. Arguing that an outdated immigration policy was holding the US back not just in its political but economic hegemony connected new ways to see people as wealth with Cold War imperatives. As Jacob Jarvits argued, a legitimate goal of immigration as foreign and domestic policy was to "attract to the free world as many as possible who are gifted and effective, who can

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[349] Shanks,*Immigration and Politics of American Sovereignty*, 6.

[350] King, *Making Americans*, 248.

make a major contribution to our society and deprive the communists of this benefit."[351] This political and economic perspective was becoming pervasive and as chapter 5 will discuss, played an important role in private and state educational policies at home was well as abroad.

This new concept of the immigrant as human capital created new constructions of "good" immigrants. In 1966, William Peterson, writing for the New York Times Magazine first coined the term "model minority" to describe the apparently unrivaled social and economic success of Japanese-Americans. Although thoroughly critiqued by Asian American studies scholars, the myth of the "model minority" remains powerful today. The 1970s and 80s, however, saw the repeated cultural reproduction of the image of Asian Americans (broadly defined) as ideal immigrants. This group of immigrants, these discourses trumpeted, had achieved middle class status and assimilated American values at a remarkable speed. As various reports insisted, Asian Americans had a higher median income, had higher levels of academic achievement, were unusually mentally and physically healthy, and had lower levels of criminality as compared to other groups.[352] As one 1971 popular article quipped, Asians were "out-whiting the Whites."[353] Furthermore, they were doing so because they came to the US with "values [that] differed very little from middle class American values—namely the belief in hard work, achievement and education, willingness to face new challenges, the delay of immediate gratification for later gain, and the importance of family life and respect for the family from the wider

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[351] Shanks, *Immigration and Politics of American Sovereignty*, 156.

[352] Futoshi Kobayashi, "Model Minority Stereotype Reconsidered.," September 1999. Accessed April 9, 2015. http://eric.ed.gov/?id=ED434167. 3.

[353] Guofang Li,, and Lihshing Wang, *Model Minority Myth Revisited: An Interdisciplinary Approach to Demystifying Asian American Educational Experiences* (Charlotte, N.C.: IAP 2008), 3.

community…"[354] [355]Nevertheless, immigrants have made use of this narrative, deploying it to their own ends in cultural debates about their place in a changing American society. Immigrant physicians in particular came to use the rhetoric of hard work and merit in response to their critics and as a reaffirmation of their place as deserving immigrants.

IMMIGRANT PHYSICIANS REPLY

Immigrant physicians and their allies to made their voices heard as much as possible, countering the growing tide of negative portrayals in leading medical forums. These responses reflect contemporary discourses about immigration, as well as draw attention to the structural flaws FMGs have been called upon to fill. Weiss's NEJM articles, for example, provoked pages of replies in the New England Journal's letters to the editor section. Many letter writers, describing themselves as FMGs, resented what they perceived as negative and unfair portrayals. Some pointed out that Weiss and colleagues' perspectives were rife with assumptions if not out rightly prejudiced. Objecting to being perceived as a threat, many of these respondents identified and challenged the rhetoric that painted them as bad or dangerous migrants, drawing instead on images of the good immigrant, including the emerging cultural trope of the "model minority." These commentaries themselves offer important contemporary critiques of the US healthcare system from a unique insider/outsider perspective, challenging alarmist pronouncements about FMGs as masks for larger structural problems in American medical education and healthcare delivery.

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[354] Aihwa Ong, *Buddha Is Hiding*, 257.

[355] Scholars and cultural critics cautioned that this apparently flattering myth, which problematically essentialized a diverse set of group experiences, could have unintended implications. One effect of this myth, for example was to diminish the challenges and ruptures that many Asians faced in the course of immigration. Another was to gloss over structural racism as surmountable, and to deny attention to members of the group that may in fact be struggling.[355]

One respondent, C.C. Sharma, objected to the portrayal of FMGs as "gangsters or… unwelcome visitors." He challenged: "the authors have presented no data… that the actual medical care delivered by FMGs is of poor quality," and added, "one cannot escape noticing that the authors were more concerned about the influx of Asian physicians than Western physicians. If this is true then…it suggests a narrow-mindedness and bigotry among American physicians."[356] M. Rammohan of Queens Hospital also objected to the generalizing discourse about "all FMGs." Challenging the authors' unsupported assumption that medical schools in non-Western countries by definition had lax admissions, arguing, "as a graduate of a distinguished medical school in India," that the selectivity of Indian medical schools is "equal of not superior to those in the United States." As another commentator pointed out, the loaded language of these and other pieces ("call[ing] our foreign colleagues names") on FMGs betray stakes beyond a dispassionate concern for public welfare, with the term "medical underground," as a "patently pejorative, emotion-laden, and unprofessional term."[357] Rammohan concurs, expressing concern that this focus on a group of apparently insidious, uncertified physicians undermines the majority of FMGs who are certified and competent, "disturb[ing] their relations with their patients and medical students," in the words of another respondent.[358]

Many of these respondents, both FMGs and FMG advocates, countered images of themselves as "deceitful, secretive, and below boards" and presented an alternative image

356 "The FMG (NEJM Correspondence)." *New England Journal of Medicine* 291, no. 17 (October 24, 1974): 916.

357 Ibid., 916.

358 Ibid., 919.

of FMGs as "good immigrants." As Ceasar Gonzales, a foreign-trained physician writing from Massachusetts asserted:

> I submit that Americans have benefited from the presence of FMGs much more than they have lost. Some of the benefits that come to mind are as follows: the great increase in the number of physicians at no extra burden to the American taxpayer or private pocketbooks; FMGs provide manpower for services that are less attractive to American physicians, freeing them for fields in which they can get more satisfaction; at bargain basement prices they do the dirty work, the tedious humdrum routine, for research and studies, enabling their American bosses to devote more time to the more important and creative aspects of research—One can just imagine how much more medical cost would escalate if these services were provided by American physicians…Most of us feel we have always done our best and have made our contribution to our adoptive country, and we protest vehemently any insinuation that we are third-class physicians.[359]

Rather than being a menace to the US healthcare system, Gonzales and many of his fellow FMG commentators assert, FMGs are an essential part of it. Furthermore, using a term such as "adoptive country" emphasizes the immigrant status of this group—recontextualizing them not as foreign invaders but as aspirational Americans. From this perspective, FMGs were not somehow profiteering from the weaknesses of the US healthcare system, but filling urgent shortages and fulfilling sorely needed roles. Gonzales, echoing broader ideas about immigrants as human capital, makes sure to note the economic role of FMGs as well, reconstructing their roles as contributors to the US medical system and American society as a whole. As Stevens Goodman and Mick conclude in their full length book on FMGs in the US, "FMGs are perhaps the most adaptable, upwardly mobile, and successful immigrant occupational group that has ever

[359] Correspondence, 918.

entered the United States."[360] These comments, reminiscent of the emerging "model minority" discourse, challenged the prevailing rhetoric, arguing that hurdles these physicians had to overcome actually made them better doctors and better citizens.

THE IMMIGRANT EXPERIENCE

Many FMGs did indeed struggle to get established professionally. Some of the NEJM commentators were not unfounded in their concerns that the American medical establishment was a major source of the barriers they had to overcome. Ironically, both negative and positive images of this new wave of Asian professional immigrants, among them physicians, subsumed the incredible vulnerability of many individuals within this group. Though they were accused of endangering Americans with "substandard" skills, as well as of abandoning those in need in their own countries, many physicians in this group saw immigration more as a necessity than as a choice. Many of these physicians faced difficult political and professional situations in their home countries. In the late 1960s, Filipinos for example, "became increasingly critical of [President Ferdinand] Marcos's corruption and alarmed by his political repression and violations of human rights."[361] In addition to the political situation, the Philippines suffered from high rates of professional un-and underemployment—with one estimate averaging 150 applicants for every job requiring higher education. Thus, many of these professionals began to migrate. Although the migration of Filipino nurses is better known, the proportion of immigrant doctors was even higher. Given the American colonial legacy in the Philippines,

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[360] Phillip C. Anderson, "Book Forum: Review of The Alien Doctors: Foreign Medical Graduates in American Hospitals. by Rosemary Stevens, Louis Wolf Goodman, and Steven S. Mick." *JAMA: The Journal of the American Medical Association* 240, no. 19 (November 3, 1978): 2101.

[361] Takaki, *Strangers from a Different Shore*, 432.

particularly in health education, (discussed in more depth in the next chapter) the fact that 40% of Filipino physicians ultimately practice in the United States is not surprising.[362]

South Korean professionals, living under a military dictatorship that supported creating a surplus of workers to ensure a compliant labor force often found immigration to be the only viable option. As one Korean physician remarked, "they have more doctors in Korea than they can support—not more than they need."[363] Many immigrants, already deracinated by migration from North Korea and forced urbanization, felt no emotional or patriotic pull to stay. Likewise, Indian physicians struggled with high rates of professional unemployment, and saw immigration as sometimes the only viable path to professional work. As a physician who came to the US in the early 70s recalls, there were simply not enough training and employment opportunities for his graduating medical school class.[364]

The urgency that pushed these groups to immigrate increased their vulnerability as new immigrants. Immigrant physicians often had to support themselves while attempting to cram for the ECFMG exam and secure a residency. As one advocate testified before the California Advisory Committee to the United States Commission on Civil Rights, "They have no opportunity to review or attend classes. They cannot afford to pay the tuition and they have no time because they have to earn living to support themselves and their children."[365] Although widely touted as an "easy" test that 98% of American senior medical students could pass, contemporary commentators felt this was an unfair comparison, arguing that American practicing physicians (who were a closer

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362 Ibid., 434.
363 Ibid, 439.
364 Arjay N. interview with author, January 2015.
365 Takaki, *Strangers from a different Shore*, 435.

comparison to many FMGs in terms of career path) would not fare nearly as well.[366] Furthermore the exam's multiple choice format was unfamiliar to many international graduates. Although some did indeed work in the healthcare field, with rural areas and state hospitals occasionally waiving or relaxing licensure requirements, many took menial jobs.[367] Sometimes those were in healthcare as orderlies and lab assistants. Often, however, they were in completely unrelated fields: one Korean surgeon found employment as a meat cutter at a restaurant, recalling in retrospect that not knowing his background his employers were impressed with his skills. A Filipino Physician described working as a hospital orderly while he prepared for his exams, as he recalls, "It was terrible, a real struggle, especially since we already had a baby at that time…but there was no turning back; my wife wouldn't return to the Philippines."[368] Given these circumstances, the high ECFMG failure rates were not as surprising.

Many of these physicians simply didn't make it into American medicine. As one reporter described the "occupational downgrading" many of these immigrants experienced, "lawyers work as file clerks, teachers as secretaries, dentists as aides, engineers as mechanics."[369] Those physicians that prevailed over these circumstances and entered American residencies remained vulnerable. Often in service-heavy programs, they had less educational time, and thus were not always as well prepared for licensing examinations. To make matters more difficult, many states placed visa and citizenship stipulations on licensure eligibility and "factored" raw exam scores differentially in favor

366 *NEJM* Correspondence, 916.

367 Derbyshire, *Warm Bodies in White Coats*, 1034.

368 Kellie Schmitt, "Importing Doctors: Foreign Physicians in Kern Share their Stories." *The Bakersfield Californian*, June 25, 2012, sec. Lifestyle.

369 Takaki, *Stangers from a Different Shore,* 436.

of US graduates.[370] In what seemed like a vicious cycle, these exam statistics, however, taken at face value were used to question the quality of FMGs, and further tighten restrictions on them. Furthermore, in some ways FMGs remained an effective "second class" of American medicine, though few complained of unemployment after residency or licensure, it was obvious that certain jobs were closed to them. Many job advertisements in professional magazines blatantly specified, "American Medical Graduates Only."[371]

In addition to contentions about competence, commentators on the "FMG Problem," in the 1960s and 70s introduced a new controversy, which became commonly known as the "brain drain." First used in the UK around this time period, the term "brain drain" initially referred to the loss of British physicians to the US and Canada. [372] However it soon became centered on poor countries, encompassing discussions of the "high rate of loss of fully trained health manpower from the medically developing nations particularly to the United States and Canada."[373] The magnitude of this issue was often expressed through highly emotive, though often unsubstantiable anecdotes. For example one story went that the first graduating class of Chengmai medical school in Thailand pooled their savings to charter a plane to the US.[374] Many contemporary scholars earnestly felt that brain drain was a serious concern, and that addressing the issue was a

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370 Arlene Goldblatt, Lewis Wolfe Goodman, and Steven S. Mick. "Reply from Authors (NEJM Correspondence)." *New England Journal of Medicine* 292, no. 18 (May 1, 1975): 984.

371 R A. Zlotoff, "Letter: 'American Medical Graduates Only.'" *The New England Journal of Medicine* 290, no. 11 (March 14, 1974): 635.

372 Oscar Gish, "Britain and America: Brain Drains and Brain Gains." *Social Science and Medicine* 3 (1970): 397–400.
Gish describes a "brain drain blame game" between the US and UK, with British legislators accusing the US of forcing them to poach 3rd world doctors as theirs are in turn poached by the US. As Wright, Mullally and Cordukes argue, however, brain drain to North America was connected to multiple factors, including a bottleneck in promotion in the British system.

373 K E. Livingston, "The Training of Foreign Medical Graduates." *The New England Journal of Medicine* 275, no. 23 (December 8, 1966): 1288.

374 Dublin, **"**The Migration of Physicians," 875.

moral obligation of the part of the United States. As Thomas Dublin argued, "one might reasonably question the wisdom, political as well as humanitarian, and the moral aspect of reliance on less well developed countries to supply a substantial portion of annual additions to the physician population of the United States."[375] The awareness of brain drain was an entrée into discussions of the larger political and economic factors that structured the "push" factors in developing countries and the "pull" factors in developed ones. Yet for others, the issue of brain drain was primarily another wedge against FMGs. Thus many critics of the "FMG problem" uncritically addressed FMGs as providing substandard care while calling for an end to talent stealing in the same breath. A summary of the "FMG crisis," again by Harold Marguiles, this time in *Hospital Progress* makes both of these arguments—reiterating his earlier studies that implied reduced competence on the part of IMGs and implicating the greed of American hospitals for keeping them from returning home and applying the skills they have gained in the US. Some brain drain arguments, however, transitioned from this broad view to a rhetoric that contributed to images FMGs as selfish and unpatriotic. G. Halsey Hunt, director of the ECFMG in 1967, for example argued that FMG's "come here because it looks like greener pastures."[376] Likewise, Kenneth E. Livingston argued that "many seek special training for prestige and economic advantage without reference to the needs of their country or its capacity to provide supporting personnel."[377]

Whether encouraging the migration of healthcare workers, along with other talented immigrants was a good or bad thing, these questions were more complex and heartwrenching than these theoretical arguments made them out to be. Some did indeed

375 Dublin, "The Migration of Physicians,"870.
376 Lyons, "Foreign Physicians, Many Unqualified,"1967.
377 Livingston, "The Training of Foreign Medical Graduates," 1288.

come to the US for better economic opportunity and the ability to "practice the best medicine in the world."[378] Many immigrant physicians, however, left difficult situations at home for an uncertain life in the US, and struggled over questions of whether to stay or return to their countries of origin.

The 1970s were a time of perhaps the most open vehemence towards FMGs in American medicine—and discourses that emerged during this period continued to have an impact for decades. Despite the controversy, foreign-trained physicians also left their own mark on American medicine. During these decades, American medicine became multicultural in a way it had never been before. Furthermore, this group contributed significantly to the feminization of American medicine. In the early 1970s, 15.3% of FMGs were female, while only 6% of American graduates were women.[379] Into the late 1990s as the number of Women entering US medicals schools rose, FMGs continued to contribute a large proportion of female doctors to the American medical workforce. [380] Although their numbers have varied, as discussed below, immigrants have become a constant presence in American hospitals and clinics. Furthermore the association between these doctors and the most vulnerable patients—rural, inner-city, institutionalized, and incarcerated Americans remains significant. Some of these effects were paradoxical, however, although this generation of FMGs, like the first generation Jews and Italians before them, wedged open an American medical establishment that was predominantly white, male, and native born. This wedge was not wide enough for all to squeeze through. As historian David Reimers noted, by 1980, for example, the number of Filipino doctors

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[378] David M. Reimers, *Still the Golden Door: The Third World Comes to America* (New York, NY: Columbia University Press 1992), 102.

[379] Stevens and Vermeulen, "Foreign-Trained Physicians,"15.

[380] S.S. Mick, and A. I. Sutnick. "Women in US Medicine: The Comparative Roles of Graduates of US and Foreign Medical Schools." *Journal of the American Medical Women's Association (1972)* 52, no. 3 (1997): 152–58.

in the US outnumbered native born Blacks who had been able to enter medicine.[381] This pattern mirrored larger cultural debates about the implications of the "third wave" of immigration for historic American minorities. Not only did the post-1965 immigrant group overwhelm the Black minority numerically, it also seemed to bypass Blacks in economic success and perceived assimilation into the American mainstream.[382] It is not surprising that this phenomenon was reflected by the demographics of American physicians. Among some ethnic groups, immigrant physicians, nurses, and other healthcare workers contributed to effects beyond their professions. Many members of this group functioned as the anchors to establish immigration possibilities for their entire families. Thus Reimers credits physicians and nurses for making possible a great deal of the Korean immigration into the US.[383]

LEGISLATIVE ACTION ON FMGS

The rhetoric of concern about FMGs had significant legislative implications. In 1976 Congress acted to place restrictions on foreign physicians aspiring to enter the US. Included in several provisions of the Educational Assistance Act, (PL-94-484) were provisions that "to some…[were] a quick and effective solution to the increasing number of physicians they consider barely competent, and will help repudiate the claim that we are importing physicians to shore up our healthcare system to the detriment of foreign health services—the so called brain drain."[384] Drawing on a Carnegie foundation study from 1975, the 1976 law declared an end to the urgent manpower shortage of the 60s and

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381 Reimers, *Still the Golden Door*, 101.

382 Frank D. Bean, and Stephanie Bell-Rose, eds. *Immigration and Opportunity: Race, Ethnicity, and Employment in the United States*, (New York, NY: Russell Sage Foundation 2003), 15.

383 Reimers, *Still the Golden Door*, 110.

384 K.M.Tan "Salvage of Noncertified FMG's." *The New England Journal of Medicine* 296, no. 21 (May 26, 1977): 1237.

70s that justified federal intervention in medical education and issues of physician supply: "there is no longer an insufficient number of physicians and surgeons in the United States such that there is no need for affording preference to alien physicians and surgeons."[385] Now this involvement was justified by the need to regulate the number of doctors. By the traditional Flexnerian logic of Medical Education policy, the absence of a shortage meant danger of a surplus and called for immediate corrective action.[386] The new restrictions required foreign-trained applicants to demonstrate that they had a place at a medical school affiliated program (where previously most were employed by unaffiliated ones), required them to pass a Visa Qualifying exam before coming to the US, and restricted their ability to convert J-1 exchange visitor visas to immigrant status.[387] Although physicians wanting to come to the US continued to demonstrate a remarkable drive and persistence even as the barriers against them grew higher, the new legislation seemed to have an immediate effect, with a 20% drop in FMGs in US residencies between 1975 and 1979, and 75% drop in exchange visitor physicians.

Although at the time, many within medicine assumed that the 1976 act was a definitive solution to the "FMG crisis," it turned out be only the beginning of a decades-long legislative tug of war between competing interests. FMG-dependent cities and states like New York, New Jersey, and Detroit protested vehemently. As a concession, legislators allowed programs that were heavily FMG dependent and provided a large proportion of Medicaid care to apply for waivers of these rules for their FMGs until 1980. As that deadline approached, however many continued to clamber for waiver

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[385] John Greene, "The Health Professions Educational Assistance Act of 1976: A New Prescription?" *Fordham Urban Law Journal* 5, no. 2 (January 1, 1977): 283.

[386] L.J. Goodman, and L E Wunderman. "Foreign Medical Graduates and Graduate Medical Education." *JAMA* 246, no. 8 (August 21, 1981): 858.

[387] Goodman and Wunderman, "Foreign Medical Graduates and Graduate Medical Education," 854.

extensions.[388] Bolstering their case were a number of studies that came out in the late 1970s, which highlighted the essential role FMGs played in caring for troublesome patient groups. In a break from earlier rhetoric, these articles portrayed FMGs as "not so bad afterall," in the words of a 1978 editorial. A 1978 article, for instance, argued that foreign trained psychiatrists in New York saw a disproportionate number of Medicaid patients. FMG's, the authors argued, were necessary in order to be able to keep the promises of the Great Society reforms.[389] Another study found the same relationship in Maryland, suggesting that the "services rendered by the FMGs are channeled to society's unfortunates."[390] By the early 1980s, Congress acted once again, this time with the result of reopening opportunities for FMGs. Ironically, this was something of an unintended effect. The 1981 report by the Graduate Medical Education National Advisory Committee (GMENAC) reawakened concerns about a looming physician surplus in earnest. With projections of a surplus of 145,000 physicians by the year 2000, Congress moved to restrict federal funding for US medical school places, effectively freezing the output of US graduates once again.[391] In 1983, in a seemingly unrelated move to cut Medicare costs, Congress instituted diagnosis-related groups, and in the process changed the way the federal government paid for graduate medical education: paying hospitals per trainee to defray education costs. This incentivized hospitals to add training spots, which without any growth in US graduates, were filled by a new, growing wave of FMGs.

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[388] Goodman and Wunderman, "Foreign Medical Graduates and Graduate Medical Education," 855.

[389] B.B. Perlman, A. H. Schwartz, J. C. Thornton, R. Weber, K. Schmidt, H. Smith, S. Nagelberg, and M. Paris. "Medicaid-Funded Private Psychiatric Care in New York City. The Role of Foreign-Trained Physicians." *The New England Journal of Medicine* 299, no. 5 (August 3, 1978): 230–34.

[390] J. Studnicki, R. M. Saywell, and W. Wiechetek. "Foreign Medical Graduates and Maryland Medicaid." *The New England Journal of Medicine* 294, no. 21 (May 20, 1976): 1153.

[391] Blumenthal, "New Steam for an Old Cauldron," 1781.

As Leon and colleagues summarize, "for five decades, medical education policy in the United States has been built around the expectation that, if too few physicians were produced, additional ones would always be available from other countries."[392] No organized medicine group or legislative body would of course admit to this in so many words. In the past few decades, however, legislative restrictions on FMGs have been loudly touted and hotly debated. Policies that have led to the expansion of opportunities for this group, on the other hand, have tended to be enacted more quietly. As the history of international physicians in the United States over the past century demonstrates, this group is most visible and controversial when related issues, such as threatened change in the US healthcare system and shifts in immigration bring up calls for restriction.

The US had not been unique among developed countries in its dependence on foreign medical labor, the UK, Canada, Australia, and New Zealand, just to name a few, have also heavily relied on international doctors to serve the needs, or at least the demands of their growing, increasingly affluent, and aging populations. What has been more unique over the past 70 years, however, is that the US does not have a healthcare system *per se*, as many of these other countries do, but rather what Laurie Abraham calls an "unsystem," a collection of federal, corporate, and professional interests with often conflicting policy goals that affect the need for healthcare providers. Oscar Gish, commenting in 1970 on the attitudinal differences between US and British policy makers toward the issue of domestic medical needs versus ethical questions of brain drain, indicates that British conversations were likely to be more productive in the long run.

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[392] Luis R Leon Jr, Hugo Villar, Christine R Leon, Shemuel B Psalms, and Gerard Aranha. "The Journey of a Foreign-Trained Physician to a United States Residency." *Journal of the American College of Surgeons* 204, no. 3 (March 2007): 486–94.

With British health care as a "nationalized industry," the government itself is empowered to "tak[e] the steps necessary to mitigate the unfortunate consequences of the present unstructured flow of medical personnel from poorer countries" as well as provide for national needs.[393] John Lister, reporting on British debates about physicians supply notes that even in a national system, "the estimation of the number of doctors needed to meet the medical needs of a country is a notoriously difficult and apparently unreliable exercise."[394] As Roberfriod and colleagues argued in a much later review article on physician supply forecasting, tellingly subtitled "better than looking into a crystal ball?:" "Only where social and political choices about access to and delivery of care are explicit, can scientific methods be used systematically to derive requirements for healthcare providers in a particular population."[395] It is one thing to determine an ideal physician to population ratio as US organized medicine organizations have claimed to do since the 1910 Flexner report, but it is a much more complex process to design a system where the population actually has equitable access to these physicians.

In the 1970s, responding to arguments that painted FMGs as a "medical underground," taking advantage of a physician shortage and putting the American public at risk, many FMGs and their advocates instead pointed to structural issues. Multiple commentators used the term "scapegoats," arguing that "the cart and the horse have somehow gotten all mixed-up here," and that critics were making the "strange inference that the foreign physicians are somehow responsible for our inability to develop post-

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393 Gish, "Britain and America," 399-400.

394 J. Lister, "By the London Post: How Many Doctors?" *The New England Journal of Medicine* 296, no. 21 (May 26, 1977): 1215.

395 Dominique Roberfroid, Christian Leonard, and Sabine Stordeur. "Physician Supply Forecast: Better than Peering in a Crystal Ball?" *Human Resources for Health* 7 (2009): 10.

graduate training programs in harmony with patient needs."[396] In the 1960s and 70s American physicians, particularly within organized medicine, felt like they were losing control of an increasingly complex healthcare system. Newly empowered groups in this field, such as legislators, hospital administrators, insurance companies, lawyers, academics, and patients did not necessarily know how to "fly the plane" either. Each had their own immediate interests and overall the tendency to seek out short term solutions over long-term gains continued to win out, particularly in terms of the issue of health manpower. The increased use of non-physician providers has also been a frequently cited option, but it was deeply unpopular with organized medicine and has taken a long time to develop. Over the course of the last 50 years, multiple urgent calls have gone out to expand and to contract American medical school admissions. This process, however, had a long lag time, and by the time expansion or restriction of medical school seats had its effect, shortage or surplus projections had often swung the other way. As Leon and colleagues argue, "the fear that expanding medical schools would guarantee a defined output of physicians that, if it were too great, could lead to excessive healthcare spending," had been a significant factor affecting the willingness of leaders to advocate that approach.[397]

In the meantime in a rapidly changing healthcare system, the use of international physicians has offered a more immediately accessible, available workforce. The flexibility of FMGs, however, is strongly tied to their increased vulnerability. Whether classed as immigrants or exchange visitors, this group of physicians is essentially at the mercy of legislative whims, and will often work in conditions or with patients American

396 *NEJM* Correspondence, 218.
397 Leon,"The Journey of a Foreign-Trained Physician," 2007.

graduates as a group would find less appealing. Although it is unlikely that any of the groups with an interest in physician manpower voiced the alternating use and restriction of FMGs as a substitute for long-term solutions, this was in many ways the path of least resistance, and had effectively become US policy for the past 60 years. FMGs remained a topic of interest throughout the 1980s, as academics and administrators continued to debate issues of physician supply and distribution. However, the 1990s saw another confluence of national uncertainty about the future of the healthcare system and soul searching on immigration, and FMGs, soon to be known as IMGs, were again in the national spotlight.

Chapter 4: "New Steam for an Old Cauldron:" Controversies about Foreign-Trained Physicians in the 1990s

If a phrase could unify the rhetoric of the late 1980s and early 90s on many issues, it would be the words "out of control." Writing in *Health Affairs* in 1994 Huskamp and Newhouse summarize the zeitgeist of current policy discussions: "health care costs, which now represent approximately 14 percent of gross domestic product (GDP) in this country, continue to spiral out of control, creating a 'health care crisis.'"[398] In an entirely different policy discussion, Alan Simpson, US senator from Wyoming thundered, "Immigration to the United States is out of control."[399] According to family physician Fitzhugh Mullan, however, "the H visa situation," for IMGs "is out of control."[400] In this decade, these words were repeatedly applied to immigration, the US healthcare system, and IMGs in American Medicine. The 90s were a time of broad readjustment for the US. With the Cold War Era definitively in the past, Americans faced the challenge of constructing new priorities for domestic and foreign policy. Even before the Cold War officially ended with the fall of the Soviet Union in 1991, perceived threats to the US shifted from military and ideological challenges to fears of increased economic competition and domestic dependency. Both of these issues pervaded debates about immigration and health care. Once again, international physicians, who despite several layers of restrictions continued to come to the US, making up 23.6% of interns and

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398 H.A. Huskamp, and J. P. Newhouse. "Is Health Spending Slowing Down?" *Health Affairs (Project Hope)* 13, no. 5 (1994): 32–38. 32.

399 Shanks, *Immigration and the Politics of American Sovereignty*,209.

400 "International Medical Graduates. Immigration Law and Policy and the U.S. Physician Workforce. Council on Graduate Medical Education Resource Paper. A COGME Panel Discussion (Washington, DC, March 12, 1996).," January 1997. 15.

residents in 1994, were at the nexus of crucial points of national anxiety.[401] On the one hand, growing dissatisfaction with the US healthcare system coalesced around divisive debates about the Clinton Administration's failed health reform plan and later about the growth of Managed Care organizations. On the other hand, the late 1980s and 90s saw major revisions of immigration law and a vehement debate that redefined images of the good and bad immigrant in a Post-Cold War era. Much as in previous decades, the foregrounding of these anxieties over immigration and the future of the US healthcare system once again harkened a period of "agitation, concern, and worry about the IMG presence in America."[402] Through a series of congressional advisory boards, reports commissioned by private foundations and organized medicine, and a barrage of academic articles in the medical literature, the role of internationally trained physicians in the US healthcare system came under scrutiny once again. This rhetorical barrage drew on specific concerns about impending developments in medicine but also channeled concurrent cultural discourses on immigration. Thus once again, stakeholders, including organized medicine groups, hospital associations, legislators, and IMGs themselves constructed and mobilized images of good and bad immigrants to pose IMGs either as problems or solutions to the complex issues of American healthcare.

The late 1980s also saw a shift in terminology, although the origin of this move is unclear, many medical publications began to refer to physicians trained outside the United States as "International Medical Graduates," or "IMGs" shying away from the potentially negative and alienating implications of the word "foreign," as well as acknowledging the complexity of a group that sometimes involves US citizens who study

401 COGME, "International Medical Graduates," 13.
402 COGME "International Medical Graduates," 19.

abroad, or naturalized Americans who hold medical degrees from other countries.[403] [404] Now more adjusted to a multicultural society and a diverse healthcare workforce, this new batch of commentators were more leery of being labeled as racist or discriminatory. In the words of Fitzhugh Mullan, advocating for restrictions on residency training slots for FMGs: "today's highly charged environment makes it difficult to consider the issue in exclusion without risking accusations of discrimination."[405] Likewise, overt distinctions between IMGs from the "3rd world," and "developed nations" were made much more rarely, at least in the published literature. Often the same concerns about quality and patriotism, whether to the US or physicians' country of origin, however, were still offered, but tended to be framed in terms of particular countries of origin. Commentators who favored restrictions on FMGs emphasized that their policies were not racially, nationally, or chauvinistically based, and though they may negatively affect a particular group of physicians, they were necessary for the imperative of the public good. Much as Flexner at the turn of the 20th century acknowledged that his reforms might well restrict the "poor boy" from studying medicine, but also affirmed that the "poor boy" had no right to enter medicine "unless it is best for society that he should," some commentators felt they were justified in singling out International graduates as a unique group.[406] This perception was enhanced by the reemergence of a very Flexnerian concern: an apparently looming surplus of physicians. The possibility of a physician glut seemed particularly

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[403] In this chapter I have tried to use the terminology of the time period I am discussing to refer to physicians trained outside the US. Thus I sue "Foreign physician" or "Foreign Graduate to discuss the 1920- 1940s. FMG or "Foreign Medical Graduate" in used in sections discussing the 1950s- mid 80s, and IMG of "international medical graduate" is used in sections describing the early 90s until the present day. All other chapters will use IMG as shorthand for this group except where contextually appropriate.

[404] A. Varki, "Of Pride, Prejudice, and Discrimination. Why Generalizations Can Be Unfair to the Individual." *Annals of Internal Medicine* 116, no. 9 (May 1, 1992): 762–64. 763.

[405] COGME, "International Medical Graduates," 15.

[406] Flexner, *Bulletin no. 4*, 43.

urgent for physicians engaged in policy, "in an era in which the medical profession as a whole is under increased attack from many external quarters."[407] As Steven Mick observed, "any medical sociologist who has studied professional dominance," will say that doctors have historically felt paradoxically vulnerable in greater numbers.[408] Thus, drawing on decades-old logic, reducing physician supply, some felt, was essential to preserving the profession's ability to weather the changes of the 1990s. In Mullan's words, "although the US has a tradition of extending opportunity to people from all over the world from whence almost all of us came…" changes to the make-up of American physicians were essential and would indeed restrict opportunities for IMGs, but "derive not from any discriminatory basis but rather from the need to manage the workforce and opportunities that are publicly funded in this country."[409] Mullan's comments reflected changing perceptions about the medical profession, but also echoed contemporary discourses on immigration. These discourses characterized the status quo as one of threat and limited resources, claiming that previous ideals of inclusion and generosity had to be sacrificed in the interest of present survival.

HEALTHCARE REFORM AND THE UNCERTAIN ROLES OF PHYSICIANS

According to political scientist Jacob Hacker, the two major foci of debate over the solvency of the US healthcare system in the 1990s were the ill-fated Clinton health plan and the rise of MCOs or managed care organizations later in the decade. Both of these developments threatened many entrenched interests in a burgeoning, "out of control," system, from organized medicine groups, to hospitals, to employers, to insurers

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407 Varki, "OF Pride, Prejudice and Discimination,"763.

408 COGME, "International Medical Graduates," 25.

409 COGME, "International Medical Graduates," 15.

and other increasingly corporate players. Each of these developments disempowered doctors' groups in its own way, heightening the perception of "attack," and "crisis." As many were becoming increasingly aware, US healthcare was "an incomplete patchwork of public and private protection that divided Americans into separate groups, missed millions entirely, and left the state bearing the medical costs of the most expensive segments of the population…"[410] In the late 1980s, signs of trouble became unmistakable, according to Hacker, "the number of uninsured Americans began to increase around 1980 and continued to grow throughout the decade, reaching 37 million in 1992."[411] Likewise, with decreased rates or unionization and an acceleration of deindustrialization, along with growing economic inequality, those losing the employer-provided private coverage were disproportionately minorities and members of the working class. Health payment reform moved on to the political stage after a long-shot senate candidate, campaigning on a platform of universal health coverage, was elected in Pennsylvania in 1991.[412] By 1993 Clinton presented his "health security" plan to Congress. Defeated by 1994, this legislative proposal nevertheless stirred up a hornets' nest of political controversy. In Hacker's analysis, although Clinton had a "flawed proposal and congressional strategy," and opposing interest groups, namely health insurers, ran an effective media campaign, including the notorious "Harry and Louise" television commercials, the real cause of the plan's defeat was the burden of history. The patchwork of the US healthcare system subdivided patients, providers, and other

410 Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States* (Cambridge, UK: Cambridge University Press 2002) 249.

411 Ibid., 261.

412 Ibid., 261.

stakeholders and prevented many groups from seeing a common interest in a reform plan, even as many of these groups chafed under the existing system.

Although as Hacker admits there were a lot potential culprits in the demise of the Clinton health plan, it "failed not because of the sniping of the once feared AMA."[413] As Peter D. Jacobson argues, organized medicine in the 1990s was a much weaker force than in prior decades. Since the 1970s it had suffered "a diminution of membership, solidarity, and political allies."[414] By the 1990s, the AMA "no longer wielded the political clout" to defend physicians' interests against what many personally saw as a more direct threat: the rise of managed care organizations. Many critics of the Clinton plan feared government intrusion into the "sacrosanct" doctor patient relationship," questioning physicians' decisions and imposing limits on care. "Ironically, the failure of the Clinton plan left the field clear for the type of radical market changes that detractors of the proposal had warned would result from its implementation."[415] Between 1992 and 1995 the health insurance industry doubled the number of Americans on managed care plans. These plans were billed as a market-based alternative to government regulation. Their purported value was the ability to cut costs to employers, insurers, and thus the entire healthcare system. Much of these savings were achieved through oversight of decisions that had traditionally been relegated to physicians. The process of pre-authorizing clinical decisions with insurance representatives, often nurses or administrators, "shakes the foundations of physician autonomy [and] imposes resource-consuming and vexing bureaucracy on

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413 Ibid., 262.

414 Jacobson, Peter D. *Who Killed Managed Care? A Policy Whodunit.* SSRN Scholarly Paper. Rochester, NY: Social Science Research Network, July 31, 2003. 372.

415 Hacker, *The Divided Welfare State*, 263.

medical practice," while leaving the physician ethically and legally responsible for the wellbeing of the patient.[416]

FEARS OF A PHYSICIAN SURPLUS

Managed care posed an additional threat, however, in that its more efficient use of physician manpower would exacerbate a truth that had become almost gospel in medical circles, that there was about to be a huge surplus of physicians. There was no doubt the physician supply was growing; although repealed in 1980, federal support to incentivize adding medical school places, (instituted to relieve the predicted shortage in the 1960s) had had its logical effect on the pool of physicians in the US. Whether they liked it or not, health resource planners saw managed care as an inevitable presence in the future of medicine. Health services scholar Steven S. Mick argued, "One important force in growth of managed care has been the growth of physician supply."[417] In the first half of the 90s, a flurry of reports, among them several by the Council on Graduate Medical Education (COGME), advisory to the Department of Health Education and Welfare, predicted a surplus of 80,000 doctors by the year 2000. Several of these reports, including the COGME, IOM, and Pew reports expressed concern that this number would be compounded with "the spread of managed care and its efficient use of physicians and physician substitutes."[418] One scholarly prediction, attempting to account for this trend, put the surplus at 165,000 by the year 2000.[419] The anticipated result of a boom in US graduates was increased competition for residency spots, and a reduction in IMGs. As a 1988 survey of hospital CEOs in the journal *Hospitals* revealed, the majority believed

[416] Jacobson, "Who Killed Managed Care," 370.
[417] COGME, "International Medical Graduates," 25.
[418] COGME, "International Medical Graduates," 25.
[419] Blumenthal, "New Steam for an Old Cauldron,"1782.

that "the burgeoning numbers of American-trained physicians have all but eliminated the physician shortage, and as a result, the demand for FMGs is shrinking…hospital executives feel that FMGs on their medical staffs may place their institutions at a competitive disadvantage."[420] There was indeed a dip in FMGs in 1989, down to 14% of total US house staff, but that dip was followed by a rapid rise up to 26% in 1994, with "the absolute number of IMG residents surpass[ing] the highs of the early 70s."[421] Thus, the issue of deeply held beliefs about physician supply connected urgent concerns about burgeoning healthcare costs and managed care to the IMGs question. When IMG numbers did not drop as predicted during the "physician glut" of the late 1980s and 1990s, a coalition of organized medicine groups such as the AAMC, the AMA, and budget-minded legislators made several attempts at legislation restricting international physicians. Some of the details of these debates, which resulted in failed legislation to cut all Medicare funding to IMG training in 1986, and a successful, less direct attempt to reduce IMG numbers through a global cap on GME funding in 1997, still drew on familiar humanitarian arguments, but increasingly the issues that seemed to count were economic and financial. The issue of whether or not IMGs were good or bad immigrants became less contingent on whether they provided needed care for Americans or citizens of their own countries, and more focused in whether they were a financial boon or burden. This language, reflected in Mullan's argument above, was tied into a larger cultural and political zeitgeist, strongly reflected in concurrent, and equally passionate debates about immigration.

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[420] K. Sandrick, "U.S. MD Glut Limits Demand for FMG Physicians." *Hospitals* 62, no. 3 (February 5, 1988): 67–69.

[421] COGME, "International Medical Graduates," 13.

POST-COLD WAR IMMIGRATION RHETORICS: MIGRATION AND NATIONAL COMPETIVENESS

As immigration scholar Cheryl Shanks argues, in the late 1980s, during the contentious immigration debates that resulted in important legislation in 1986 and again in 1990, "Cold War reasons gave way to economic reasons in spite of objective similarity among circumstances the legislators discussed and in spite of the Cold War's intensification."[422] This stream of rhetoric resulted in a radical reconfiguration of American cultural images of the good and bad immigrant. Arguments about the "ideological[l] significance" of immigration in the context of rivalry with the Soviet Bloc gave way to arguments about "fears of hegemonic decline and loss of global competitiveness," particularly to the rising economies of Germany and Japan. By the mid-1980s, claims in debates about immigration were legitimized "almost solely in economic terms." Thus immigrants were assessed on whether they brought in capital and skills, or "absorbed funds that could have gone to citizens dislocated by American economic upheavals."[423] At a time when the US GDP was higher than ever, rhetoric about immigrants becoming "public charges" was reminiscent of Great Depression-era debates. Most tellingly, "the 'why' changed more than the 'who,'" and the selfsame groups of immigrants were re-characterized according to these new standards. Cubans and Soviet-Jewish refugees, for example, previously welcomed as ideological capital in the Cold War struggle were re-classed as "economic migrants," "seen primarily to flee economic distress…and cause it in the United States."[424] Previously painted as freedom seekers escaping oppression for the opportunity of America, these groups were now

422 Shanks, *Immigration and the Politics of American Sovereignty*, 190.
423 Ibid., 188.
424 Ibid., 196.

portrayed as dependents dumped on the US by governments that did not want the responsibility of supporting them. This traditional debate about how the legislature should respond to immigrants it could regulate took place in the context of another debate about a "silent" immigration, described as an "invasion… occurring mainly at night across our unprotected borders."[425] Undocumented immigrants from Mexico and Latin America, who "through some trick (that Americans never seemed to master) managed both to take jobs from Americans and go on welfare," became the object of public and legislative ire.[426] Immigration rhetoric painted the stakes for reform as very high, as Shanks argues, the thrust of much of the rhetoric of this era was, "good economic immigrants were necessary for the country to survive and even dominate; bad economic immigrants would devastate the country's chances to exceed Japan and Germany."[427] This view of immigrants as "primarily factors of production," allowed American legislators to stop worrying about whether or not an immigration policy was "discriminatory," the big concern of the last set of reforms 20 years before.[428] Under these new terms, national survival was linked to national competitiveness, and thus denying entry to a group that threatened this competitiveness was unfortunate, but imperative. Accepting non-productive immigrants was "a luxury the US could no longer afford."[429] As West Virginia Democrat Jennings Randolph put it, "If the United States is to continue to preserve a stable economic and political sovereignty in the face of multitudes yearning for freedom and opportunity, we must temper our compassion and

[425] Ibid., 190.
[426] Ibid., 198.
[427] Ibid., 197.
[428] Ibid., 202.
[429] Ibid., 208.

generosity."[430] The outcome of these debates was a two-step amendment to US immigration policy. The first step, the 1986 Immigration Reform and Control Act, or IRCA, was seen as a way to fix the problem of "unproductive," "illegal" immigrants. The act coupled a path to legalization for some undocumented US residents with more restrictive laws aimed at employers of undocumented immigrants. The 1990 Immigration Act was meant to bolster American competitiveness by attracting "productive" immigrants. While adding some limits to family reunification by including these immigrants into national quotas, the act emphasized the migration of highly skilled workers and professionals, and also contained a provision for investors who would put 1 million into the US economy and create 10 jobs within two years.

FROM "CHEAP" TO "EXPENSIVE" LABOR

Logically, one would assume that immigrant physicians would be a perfect example of the newly preferred group of immigrants, ones that not only "pulled their own weight," but also contributed to society as producers and consumers, bringing their technical skills and capital to the US, rather than to its competitors. In fact the 1990 act did make more H1B skilled worker visas available to international physicians. This fact, however, was not well received by a medical community that felt that it was in crisis (hence Mullan's description of the H1B situation as "out of control.") In the context of the debates about the American healthcare system described above, IMGs were more often rhetorically classed with the dangerous, newly restricted group of immigrants. Arguments against IMGs from the 1970s, no matter how vituperative, could not deny that they filled a public service need in the United States. At the time, however, the broad

[430] Ibid., 208.

consensus among physicians, health services scholars, and legislators was that the US suffered from an acute physician shortage. Debates from the 1970s, on either side of the foreign graduate issue, employed the somewhat derisive but telling term "cheap labor." The implication of this term, depending on who wielded it, was that IMGs were either being exploited to avoid heavier costs to the public and private system or that they were undercutting American physicians. In the debates of the late 80s and 90s, IMGs suddenly became "expensive labor," that is more attention was paid to the cost of their training to US public coffers than to the value of the labor they gave in exchange. In Fitzhugh Mullan's words, the policy debate about IMGs, "is principally an educational issue and an issue, with regard to Medicare dollars, of investment, how we wish to invest large, valuable, hotly contested public US-taxpayer-derived dollars."[431] Arguing in support of his bill to cut GME funding to IMGs, Senator Bob Dole emphasized cost-savings as his primary concern, adding "if in fact this nation believes we should continue to assist in the training of foreign physicians…such funding might more appropriately come from non-patient revenue sources." Writing in 1986, health policy analyst John Igelhart remarked that increasingly restrictive IMG legislation proposals were being proposed in the context of "an ongoing struggle by government to gain control of federal spending and reduce massive deficits."[432] Whereas an older generation of medical academics were concerned that IMGs were failing to return home after their training, those of the 1990s were also concerned about the opposite, that IMGs were in fact going home and taking the American public investment in their educations with them.

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431 COGME, "International Medical Graduates," 16.

432 J. K. Iglehart, "Reducing Residency Opportunities for Graduates of Foreign Medical Schools." *The New England Journal of Medicine* 313, no. 13 (September 26, 1985): 832.

Just a generation earlier, international exchange in medicine was viewed as vital to US foreign policy, fostering international goodwill and assisting US ideological goals. By the late 1980s, however, these perspectives had become almost incomprehensible. As Igelhart observed at the time, "there has been no discussion of [the] foreign policy implications," of restricting IMGs. Mirroring the general rhetoric on immigration, legislators and many medical leaders now felt America in general, and American medicine in particular, could no longer afford to be generous to the less fortunate. This rhetorical reversal did not obviate the brain drain debate, however, and negative images of IMGs as both as a drain on American educational resources, and as unpatriotic citizens who "deserted their country of origin in its hour of need" were both deployed simultaneously.[433] Both of these arguments however, were based more in rhetoric than fact. Over the decades, keeping track of IMGs that return home has been a notoriously difficult project.[434] Regardless of challenges of record keeping, in 1995 50% of IMGs were permanent residents, as well as native and naturalized US citizens—a status that gave this group moral and legal claims to inclusion.[435] Proposals such as Dole's legislation did not appear to take that fact into account, characterizing all IMGs as "foreigners" in the country through American generosity, rather than acknowledge a fact little known outside of medicine, that half of this group were in fact Americans, and were

433 Varki, "Of Pride, Prejudice, and Discrimination," 763.

434 Although many J-1 visa holders are legally required to return home for a minimum 2 year period after training, national interest and "interested government agency" waivers have been used, to varying degrees, to allow IMGs to stay in the country and sometimes convert to immigrant status. Additionally those J-1 holders that do leave the US for 2 years as required by law potentially return as immigrants. Likewise, physicians with multiple citizenships, and alternative types of visas may come and go to the US with little way to keep track of them. It has been relatively apparent that most physicians who come to the US, even in J-1 and H1B visas say for at least some period of time after training, with many choosing to permanently relocate the US.

435 These physicians either gained immigrant status through family reunification provisions, refugee status, or other immigration pathways that were not dependent on their identity as physicians *per se*. This group also included US citizens, native or naturalized, who traveled abroad, exclusively for medical studies and subsequently returned to the US.

no less likely to use their training in the US than any graduate of a US medical school. This assumption on the part of congressional legislators and decision makers within medicine reveals how little stakeholders often knew about this group of physicians. The IMG debates of the late 80s and early 90s echoed the general divisions within immigration debates in a changing America, a context in which, in Cheryl Shanks's words, "those who believed immigrants drained resources struggled against those who claimed that they contributed far more than they took."[436] Claims that this group disproportionately served poor and otherwise vulnerable populations still had weight, but not as much as they had previously, after all, in serving this group of dependents physicians were not generating any wealth or creating jobs. Arguments that IMGs helped the US fulfill its societal obligations carried less weight in an environment in which many legislators were desperately trying to repudiate responsibility for them.

ORGANIZED MEDICINE LOBBIES FOR RESTRICTIONS ON IMGS

In a climate of panic about a looming physician glut, organized medicine circled the wagons against IMGs—many portrayed this as a regrettable choice, but one that was urgently necessary to avoid dire consequences. Oddly enough, for many, the need to restrict IMGs was less about IMGs themselves than it was about Americans. The reasoning of organized medicine leaders echoed similar logic, employed by their "less enlightened" predecessors in the 1920s and 30s against the threat of American medical students who, denied admission in the United States, pursued study abroad. As described in a previous section, in the nativist 1930s, this group, often the children of Jewish and Italian immigrants, was particularly distasteful to the AMA. The great depression hit

[436] Shanks, *Immigration and the Politics of American Sovereignty*, 212.

many practicing American physicians very hard and these students were seen as subverting the AMA and AAMC's rational and necessary limits on physician numbers. An overcrowded profession would increase competition among already struggling physicians, as well as make them weak in the face of the threat of a growing government role in healthcare. In the 1990s with almost all voices again fearing surplus, physicians sought to respond to a new threat, the growing role of corporate entities, in the form of MCOs and hospital corporations in US healthcare. As Paul Starr argued in 1982, "the great irony is that the oppositions of doctors and hospitals to public control…set in motion entrepreneurial forces that may end up depriving [them] of their traditional autonomy."[437] In the 1980s and 90s, organized medicine leaders relied on a near century-old Flexnerian logic of weakness in numbers to retain this authority, moving to cut medical school enrollment. A contemporary PEW health commission report suggested dropping US medical school places by 20%. Dr. Neal Vaneslow of the AAMC summarized the resulting concerns in a Congressional hearing: "what we are finding is that schools in this country are under tremendous pressure to decrease class size…what we are afraid will happen, because foreign schools are not under that pressure, is that the students that don't get into US and Canadian schools will simply go to foreign schools, and in effect we will be substituting well-trained physicians for physicians who are not trained as well." Age old doubts about the relative quality of IMGs, whether from the US or abroad also contributed to the rhetoric of the era's debates. Legislators highlighted the 1983 conviction of a broker who sold medical diplomas from fraudulent international medical schools to Americans. Florida Congressman Claude Pepper was particularly

[437] Starr, *The Social Transformation*, 445.

vehement about protecting "innocent Americans," from the problem of "phony doctors."[438] Much like the "medical underground" scandal of the 1970s, this rhetoric brought additional calls for regulation and heavy scrutiny down on IMGs as group, even though the great majority had attended reputable medical schools.

Analysts like Mullan saw American medicine as facing a choice between massive cuts in medical schools or "severe restriction of funding for IMGs," in hopes of avoiding both outcomes. In Ingelhart's analysis, in a setting of limited resources, somebody had to go, and "reducing the foreign medical graduate population…is the only palatable way to cut the number of residency training positions."[439] Thus when Senators Bentsen, Dole, and Durenberger proposed S. 1158, which would have cut Medicare funding for training spots occupied by an IMG, even they were surprised at how enthusiastically the AAMC, the AMA, and the AHA came out in favor of the bill. Although this reaction was not particularly surprising from the AAMC, who clearly had an interest in restoring its control over the physician workforce, the AMA's stance was more internally controversial. By the mid-1980s, 35.7% international medical graduates were AMA members. Likewise, 22% of Americans studying medicine abroad were the sons and daughters of AMA members.[440] Given the perception of crisis, however, it seemed that restrictionist forces within the organization won out, and the organization put the purported interest of the profession above that of its own children.

438 Iglehart, "Reducing Residency Opportunities," 833.
439 Ibid., 836.
440 Ibid., 835.

IMGs Organize

The 1986 proposal to cut funding to IMG positions was ultimately unsuccessful. Partly this was because of the infeasibility of such a policy for the still heavily-IMG dependent Northeast, particularly New York and New Jersey. Another contribution, however, was a growing movement of IMG activism. Stevens and Vermulen describe the plight of many FMGs, often investing heavily to come to the US only to encounter significant barriers to actually practicing their profession. Despite changing legislation, many IMGs were not able to re-establish their careers in the US, leading to what many have come to call "brain waste." With a heightened awareness of this vulnerability, some FMGs began to organize. Leery of periodic rhetorical attacks from legislators, and all too aware of the everyday ways in which these sentiments played out in professional interactions, most IMG groups began as ethnic and religious societies. Groups such as the American Association of Physicians of Indian Origin, the Association of Pakistani Physicians of North America, the Islamic Medical Association, and the Association of Philippine Physicians in America, mainly formed in the 70s and 80s, began as mutual aid and social groups, with political activity serving as only a small and inconsistent part of their goals. Many physicians felt more comfortable in more locally based organizations, often consisting of alumni of particular medical schools or individuals who identified with particular cities, states, or regions. Often these societies would organize to help newly arrived compatriots or to send resources home. As internist Ajit Varki argued in a 1992 article in the *Annals of Internal Medicine*, FMG, and for that matter, IMG, was a "flawed characterization," used to group together an extremely varied group of professionals. Many physicians, he argues do not identify with being FMGs *per se*,

except when the category is imposed on them from the outside.[441] This diversity has been one of the challenges in the way of the creation of sustained IMG pressure groups and lobbying efforts. Founded in 1975, the American College of International physicians was the first group open to IMGs of all backgrounds and though it outlined a legislative agenda and identified issues of common concern, ultimately it did not last as a unifying group.[442] By the mid-1980s, however, a loose coalition of IMG groups, concerned about the tone of federal legislation and AMA rhetoric began to court relationships with congressmen and eventually hired a lobbyist. Within the AMA, these groups also pushed for an IMG section to help represent their interests.[443] In 1989 the International Association of American Physicians held a "Rally for FMG Rights," at the US capitol. The move to organize was not universally popular, especially given the diversity of this group. As Varki argued in 1992, although he did not "intend to demean the efforts of many who have lobbied and fought for the rights of 'FMGs,'" he was concerned that these efforts can also serve to emphasize and perpetuate this flawed characterization, and can hurt as much as they help."[444] Instead he argued for the need to push toward a change of attitude in the American medical profession to see IMGs as individuals rather than members of an artificial group.

Whether IMGs felt they had a common identity or not, 80 years of rhetoric had ensured that this categorization had strong staying power. In a climate of apparent increasing hostility towards them as a group, IMG responses, on an individual and collective basis, challenged views that classed them as foreign. In a climate of

441 Varki, "Of Pride Prejudice and Discrimination," 763.
442 Shawn McMahon, *Fight for Equality*, 51.
443 McMahon, *Fight for Equality*, 61,89.
444 Varki, "Of Pride Prejudice and Discrimination,"763.

contentious debates about illegal immigration, being foreign could mean being viewed as an expendable consumer of resources. As Susan Martin, of the US commission on immigration reform remarked as a part of a 1996 COGME panel, "the American public tends to not understand the difference between the two types [legal and illegal] immigration…the perception that our immigration system is out of control makes it very difficult to have a generous humanitarian-based immigration policy in terms of legal admissions."[445] Many emphasized that 50% of IMGs were US citizens or permanent residents, and thus contributing members of society who had legitimate claims to resources and fair treatment. As one audience commentator at that the COGME panel, apparently an IMG, argued, "my concern is about physicians who are US citizens, green card holders…I hope we remember that those are US citizens as much as anybody else…I've been here 27 years. I have been president of the chamber of commerce, president of the school board…I pay my income taxes and my social security taxes…Then you tell me…'we will not pay your medical education' it's downright un-American, it's Illegal, it's immoral."[446] Another thrust focused on the economic value of IMGs. In an era of concern over national competitiveness and federal solvency, purely humanitarian arguments about IMGs caring for needy patients were not effective alone. AppaRao Mukkamala, an Indian-educated radiologist practicing in Michigan, speaking as part of the same COGME panel discussion, began his talk with these considerations, emphasizing that "IMG's presently in the US…pursued their education outside the shores of this country at no cost to the taxpayers of this country."[447] In remarking that "IMGs are filling the slots left unfilled by USMGs…we are not displacing anyone from his or her

[445] COGME, "International Medical Graduates," 43.
[446] COGME, "International Medical Graduates," 50.
[447] COGME, "International Medical Graduates," 46.

position," he also appealed to pervasive American concerns about immigrant labor. Another IMG on the panel, Sergio Bustamante of New Jersey, seconded this sentiment: "I can tell you no program director is going to be hiring IMGs in preference over USMGs." Mukkamala continued, the physician labor force would be best regulated as "a free market system," he argued, and reducing the numbers of IMGs would constitute inappropriate interference.[448] Although this argument perhaps demonstrated a misunderstanding of healthcare financing, it too, was very much in keeping with influential economic discourses of the period.

Bustamante, much as many IMGs had in the 1970s, argued that the real issue was a broader dysfunction of the US healthcare system: "we need to have some kind of understanding that the public should not perceive this as a foreign threat but as a problem locally produced within the US…"[449] Because of their particular positionality, internationally-trained physicians were more attuned to the "doublespeak" on IMGs in the US healthcare system and its relationship to deep structural dysfunction of that system. As Abraham Verghese, who arrived in the US in the 1980s summarizes it:

> The schizophrenia and doublespeak were not lost on us and, in fact, were rather amusing. On the one hand, the Educational Commission for Foreign Medical Graduates (ECFMG) seemed to throw up more hurdles each year, more hoops so that the FMGs who made it to the United States had to have the resilience of Job and had to listen to the American Medical Association and others bluster over what this influx was doing to the projected physician "surplus." But on the other hand, program directors in many hospitals relied completely on this foreign workforce, signing us up often sight unseen, sponsoring us for visas, advancing us the first month's salary, helping us find housing, and welcoming us.[450]

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[448] COGME, 46.

[449] COGME, 33.

[450] Verghese, Abraham. "Resident Redux." *Annals of Internal Medicine* 140, no. 12 (June 15, 2004): 1034–36.

THE FERVOR COOLS: FILLING THE DEMOGRAPHIC, FINANCIAL, AND MORAL GAPS IN US HEALTHCARE

In 1986, American legislators had not acted to curtail funding for IMG residency training, ultimately concerned that this would result in significant disruption to inner city hospitals in many parts of the country. A suggestion to cut GME funding to IMGs by 25% remained politically viable into the 1990s. In addition, the COGME proposed the 50/50/110 plan, to use residency funding to shift the mix of American physicians to 50% primary care doctors and 50% specialists, while reducing available residency spots to 110% of US medical school graduates.[451] The latter provision had the advantage of appearing to discriminate against IMGs only indirectly in the service of the public good. Debated throughout the 90s, these suggestions ultimately ran into the same roadblock as Dole and Dulenberger's plan; evidence was mounting that IMGs plugged too many gaps in an increasingly troubled and controversial US healthcare system. Both as residents and as full-fledged physicians IMGs fulfilled crucial roles that were unlikely to be filled by US graduates, particularly as their numbers declined and projections of physician surplus militated against expanding American medical schools. Although no one could deny that FMGs provided service to otherwise forgotten groups as residents, whether they continued to do so after residency was controversial. Although statistics were widely available, their interpretation is complex and has varied, often correlating interpreter's predetermined stance on restricting IMGs.[452] As Mullan, Politzer, and Davis argued in 1995, given the opportunity, IMGs subspecialized with the same gusto as Americans,

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[451] Blumenthal, "New Steam for an Old Cauldron," 1783.

[452] S.S. Mick, S.Y. Lee, and W.P. Wodchis. "Variations in Geographical Distribution of Foreign and Domestically Trained Physicians in the United States: 'Safety Nets' or 'Surplus Exacerbation'?" *Social Science & Medicine (1982)* 50, no. 2 (January 2000): 185–202.

furthermore, "apparently IMGs are filling residency and staff positions in smaller communities, but when "free" to locate to an office practice after completing training, they select the same urbanized pattern of communities as their USMG counterparts."[453] Mick and Worobey disagreed, analyzing data by region and by state, rather than nationally, they determined that FMGs were "differentially distributed across measures of specialization, geographical location, and type of practice."[454] A drop in IMGs, they argued, would exacerbate the disproportion of specialists to generalist, reduce the numbers of physicians in solo and group practice, and reduce the number of physicians in small towns and rural areas, particularly in the North-Central and Southern regions in the US. [455] Restricting the number of FMGs, they warned, would not necessarily mean that American graduates would fill the jobs they leave behind.

The crisis of IMGs was tied to the crisis of the inner city and of US community hospitals, as well as to long term concerns about medical care in rural areas and small towns. These issues, though going on for some time, became more visible in the 1990s. With statistical analyses such as Mullan's and Mick's often contradicting each other, emotive and anecdotal appeals had surprising weight for legislators—ultimately softening stances toward restricting IMGs. As Igelhart remarks, the division on this issue in Congress was often geographical rather than along party lines. With urban democrats from New York City and New Jersey and small town Republicans from Nebraska and Upstate New York sharing their constituents' concerns about being able to access medical care. Amo Houghton of Upstate New York, for example, worried how his home

[453] F. Mullan, R. M. Politzer, and C. H. Davis. "Medical Migration and the Physician Workforce. International Medical Graduates and American Medicine." *JAMA: The Journal of the American Medical Association* 273, no. 19 (May 17, 1995): 1525.

[454] Mick and Worobey, "Foreign Medical Grads in the 1980s," 87.

[455] Ibid, 99.

town of 12,500 would attract doctors without IMGs, while self-styled Reagan Republican Jon Christensen told of a Turkish oncologist who had taken care of his father in Grand Island, Nebraska. As several health sciences scholars pointed out in this period, IMGs had come to take on a role that had traditionally been particularly vital to rural areas. By the mid-1990s, Stephen Mick calculated, IMGs made up 53% of the nation's trainees in primary care.[456] This division of labor in American medicine, between primary care specialties such as Family Medicine, Internal Medicine, Pediatrics, and OB/GYN and specialties such as plastic surgery, radiology, anesthesiology, ophthalmology etc, once a matter of shoptalk, had become an important issue for public discussion. On the one hand, the question of out of control cost increases in US healthcare brought attention to overtreatment and the heavy use of technology, often by medical specialists. The ascendance of managed care was based on a system that relied on primary care providers as gatekeepers to this more costly care. Perhaps because of this apparently pedestrian role, primary care drew less reimbursement from traditional insurance schemes and less interest from American medical students. As Americans came to realize the value of primary care, American organized medicine began a push to produce 50% generalists graduating from American medical schools in the 1990s. Meanwhile, however, large areas of the US were critically short of generalists. Although experts disagreed over to what extent IMGs filled the gap, drawing on them was politically easier and more immediate than either changing the specialization culture in American medical education or training non-MD primary care providers such as NPs or PAs.

[456] COGME, "International Medical Graduates," 22.

On the other side of the demographic spectrum, the problems of poverty in the American inner city had only appeared to grow in the 1980s and 90s, and the situation of the hospitals that served these areas grew increasingly acute. In her book 1992 book, *Mama Might be Better off Dead*, journalist Laurie Abraham describes the social abandonment of the American inner city and its devastating impact on health and health care through a study of North Lawndale, a majority African American and Hispanic Chicago neighborhood. In the 1990s, the situation of hospitals such as Michael Reese and Mt. Sinai, originally built to serve the area's mostly Jewish population earlier in the century, was growing critical. "Only 6% of Mt. Sinai's patients are covered by commercial insurance," she notes, creating a situation where, "more than perhaps any other hospital in the Chicago area, its leaders have chosen to devote the institution to serving its natural constituents, the poor. But only great ingenuity and commitment have allowed the hospital to survive."[457] "Hospitals in impoverished areas," she continues, "have fallen in great numbers…the more hospitals that close, the greater the burden on those that remain and the higher the chances that they too will succumb."[458] As Hacker argues, the 90s saw an unmistakable corporate shift in medicine, with a "wave of mergers and acquisitions," resulting in the growing influence of for-profit hospital chains.[459] These hospitals would often acquire and close or greatly change the mission of these struggling traditional institutions. This issue became prominent at the 1996 COGME panel discussion, with multiple references to the closing of hospitals—something most saw as a factor exacerbating the perceived physician surplus. Inner city hospitals saw a disproportionate number of what Abraham called "sociomas," "social problems that

[457] Laurie Kaye Abraham, *Mama Might Be Better Off Dead,* 6.
[458] Ibid.
[459] Hacker, *The Divided Welfare State,* 263.

range from not having a ride to the doctors' office, to drug addiction, to homelessness, to the despair that accompanies miserable life circumstances."[460] A 2000 human interest piece in the Washington Post, describes a bewildering situation in which, "foreign medical graduates…with the least prestigious and often toughest assignments…team up with largely foreign-trained nursing staffs to create a heavily international force that battles medical problems with often uniquely American social roots: drug abuse, gunshot wounds, and child abuse."[461]

The HIV/AIDS crisis of the 1980s and 90s compounded but perhaps most importantly, symbolized this disproportionate burden—figuring prominently in the early career experiences of IMGs who came to the US during that period. The same article quotes a nephrologist, originally from India, working at King's County hospital in Brooklyn, "There was AIDS, the worst of it…there were patients with open sores; patients died all the time. This is very depressing. It turned off quite a number of American graduates."[462] These thorny and unpleasant realities lay behind the terse statement by AAMC representative Jordan Cohen, that too abrupt a reduction in IMGs "would wreak havoc to some important institutions." As the emergence of these emotive images of need in rural and urban US healthcare demonstrates, the "gap filling role" of IMGs was not just demographic or financial, but in some ways moral—the assurance that someone was indeed taking care of these urgent human needs.

Thus in the late 1990s, the IMG issue touched on some of the major debates not just about the future of American health care, but also about American society.

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460 Abraham, *Mama Might be Better off Dead*, 4.

461 Fletcher, "Cultures Converge in Public Hospitals," no pg.

462 Fletcher, "Cultures Converge," no pg.

Interwoven, and sometimes unspoken in legislative and organized medicine discourses of restricting IMGs were issues of the increasing corporatization of medicine, physicians' feared loss of professional autonomy, the alarming rise in healthcare costs, and the growing dissatisfaction from all sides in a healthcare system that seemed increasingly patched together. At the same time, these debates implicated some of the most contentious social issues emerging in this era, growing economic and racial inequality, the embattled healthcare safety net, diseases of poverty such as drug abuse and HIV, and finally questions of immigration in a post-industrial, increasingly economy-focused culture. In many cases, it was simply much easier to discuss whether to restrict or leave the door open to IMGs than confront the underlying issues. As Cheryl Shanks argues, broad immigration policy debates of this era saw called for reform that would attract more skilled, highly trained immigrants to help expand domestic investment and retool the post-industrial US economy. The mostly unspoken alternative, she argues, would have been "to construct…a policy guiding labor education and retraining, and investment in manufacturing and research."[463] The later policies would have been infeasible because of their cost and ideological contention across the political spectrum. Immigration, though itself controversial, was a much easier answer.

Ultimately, concerns about the alternatives to IMG roles in the US healthcare system somewhat tempered the rhetoric of restriction. National and professional policies of the late 1990s had mixed results for IMGs but ultimately did little to restrict their numbers. In 1997, as a part of the Balanced Budget Act, Medicare support for residency

[463] Shanks, *Immigration and the Politics of American Sovereignty*, 226.

positions was capped at 1997 levels.[464] While this restriction did not appear to differentially target IMGs, the hoped-for result was a gradual diminution of this group as the number of American graduates built up. One year later, the ECFMG instituted an additional exam for both American and International medical students, known as the STEP2 CSE. This exam, utilizing standardized patients in a simulated healthcare setting was intended to assess clinical proficiency as well as spoken language skills appropriate for a US context. This exam has proven to be an enormous barrier to many international physicians aspiring to come to the US, not so much because of any innate difficulty, but because it is only offered in a limited number of testing centers inside the US.[465] Thus physicians have to obtain a visitor or tourist visa just to take the exam, as well as pay for airfare and the testing fee, which by itself can be the equivalent of a years' salary for a physician in a low to middle-income country. This significantly raises the stakes. One physician described saving for several years in order to pay the cost of the test. [466] In another sense, IMGs achieved a small victory, after years of internal lobbying, and periods of frank hostility the AMA established a permanent IMG section to "serve in an advocacy role within the AMA on IMG issues."[467] Commentators such as Paul Starr observe the AMA's overtures towards its IMG members as a sign of the overall changing nature of the organization from a powerful leader to more of a physicians' union. Likewise, the 1990s saw a streamlining of the often chaotic process for J-1 visa physicians applying for a public interest waiver to stay in the country. The 1994 Conrad-

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464 Blumenthal, "New Steam for an Old Cauldron," 1782.

465 Leon, "The Journey of a Foreign Medical Graduate."

466 Esther L., Interview with author Feb 2014

467 American Medical Association, "Evolution & History of the IMG Section." Accessed April 9, 2015. http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates/about-us/evolution-of-img-section.page.

20 program (expanded to 30 in 2003) allowed each state to sponsor 20 IMGs on visitor visas to work in an underserved area after residency and be allowed to convert to immigrant status. [468]

IMGs and American Medicine in the Twenty-First Century

Much like legislative attempts to restrict IMGs in the 1970s, the rules of the 1990s may have had very material effects on the situations of individual physicians, but did little to change the overall role of IMG in the US healthcare system. The percent of IMG trainees did drop to about ten to fifteen percent of residents at the turn of the millennium. However in 2006, IMGs continued to make up ¼ of American physicians, and in 2012, 10% of hospitals remained IMG dependent.[469] As they became the subject of scrutiny, rules, and rhetoric, however, individual internationally-educated doctors become increasingly vulnerable. Immigration stories that involve varying lengths of unemployment, great expenses of money and time, family hardship, and personal uncertainty are just as familiar to many IMGs in the 1990s and 2000s as they were in the 1970s, and for that matter in the 1940s. A study of IMGs who became ECFMG certified in 2006, for example, demonstrates that 50% were unsuccessful in getting a residency on the first attempt. In 2010 only 75% had achieved this goal.[470] In Interviews with 7 IMGs who trained in the 1990s and 2000s, for example, the majority had to wait either in the

[468] Amy Hagopian, Matthew J. Thompson, Emily Kaltenbach, and L. Gary Hart. "Health Departments' Use of International Medical Graduates in Physician Shortage Areas." *Health Affairs (Project Hope)* 22, no. 5 (October 2003): 241.

[469] Giovanni Traverso,, and Graham T McMahon. "Residency Training and International Medical Graduates: Coming to America No More." *JAMA: The Journal of the American Medical Association* 308, no. 21 (December 5, 2012): 2193.

[470] Paul Jolly, John Boulet, Gwen Garrison, and Mona M Signer. "Participation in U.S. Graduate Medical Education by Graduates of International Medical Schools." *Academic Medicine: Journal of the Association of American Medical Colleges* 86, no. 5 (May 2011): 559.

US in their country of origin, sometimes for a period of years, or described multiple yearly cycles of applying. One individual described applying to 60-80 programs in order to receive 3-4 interviews. Some reports from the 1990s describe IMGs in California buying spots in residencies.[471] Thus much as after the last period of restriction in the 1970s, IMGs have shown a remarkable persistence and drive, continuing to pursue careers in US medicine despite new obstacles. IMGs have remained a flexible workforce, available to compensate for the manpower shortages and other structural deficiencies of US healthcare. This flexibility often comes at a significant price to these individuals, however. Since the late 1990s, there has been a great deal of dynamism in the US healthcare system, as well as changing rhetoric and legislation on immigration. None of these changes, however, have necessarily made the US healthcare system a more stable, predictable entity. With developments like the Affordable Care Act, aimed at reforming the US healthcare system, still leaving in place a complex network of competing interest groups, predictions for the future can be contradictory. IMGs have been described both as likely to expand in numbers and as likely to be increasingly squeezed out of American medicine. Given a long history of restriction and resilience, recent expert predictions that forecast a drop in IMG numbers, are worth examining, but may prove just as fallible as any number of such pronouncements over the past 60 years.

The future course for IMGs is as uncertain as the future of the healthcare system they are striving to practice in. Factors that have always affected the rhetoric about IMGs such as uncertainty about the fundamental state of the US system of health provision and related discussion of physician supply, as well as contemporary discourses on

[471] McMahon, *Fight for Equality*,53.

immigration have continued to have a role in the 21st century. The last 15 years have seen debates around the eventual implementation of the Affordable Care Act, as well as new exclusionary and surveillance-heavy immigration policies since the September 11th, 2001 terrorist attacks. Additionally, the emergence of the global health movement in academic medicine, particularly in the US and the UK, has revived conversations about brain drain and the ethics of migration. Perhaps as importantly, these years have also been a period of increased globalization, where the very idea of what it means to be an immigrant and what it means to be a citizen continue to be reconstructed. The global phenomenon of peripatetic physicians has now affected several generations of trainees and practitioners, and these emerging attitudes toward migration and national and professional identity have been intertwined with this heritage. Catherine Ceniza Choy has called this "a culture of migration," a situation where migration comes to have particular cultural meanings and can become integral to professional identity.[472] Likewise, increasingly global information networks, and the Americanization of medical education in many places of the world is both affected by and itself affects this scenario. I will explore some of these issues in their complexity in later chapters of this project, though I hope to summarize a few of the basics here.

As David Blumenthal notes, the great irony of much congressional and professional action on physician supply is that by the time it is enacted, the expert predictions have often reversed themselves. Almost as soon as Congress and organized medicine organizations acted to cap residencies and increase barriers to IMG certification, the predictions of a looming physician surplus that justified these actions

[472] Choy, *Empire of Care*, 4.

began to unravel.[473] One factor was "the healthcare equivalent of the nonevent that was Y2K." Many of the physician supply projections were calculated for the year 2000. When that year arrived and "no one saw a real doctor on the corner selling pencils," the "medical establishment's view of the physician supply" was profoundly shaken.[474] Prior projections, it seemed "overestimated the effects of an aging, chronically ill, and increasingly demanding population."[475] Perhaps more cynically, some studies of the period, namely by Richard Cooper, argued that demand for physicians in the United States tracked per capita GDP more than any other factor. Thus given the rise in wealth in the US, demand for physicians would grow, and the country, in fact had a shortage of physicians, particularly of specialists.[476] Another projection in 2004 estimated a shortage of 85,000 physicians by the year 2020. By 2004 both the AAMC and the AMA "abandoned previous projections of physician surplus."[477]

Prognostication in an unstable system characterized by a panoply of competing interests, is, however, a fool's errand. With a growing awareness in the mid-2000s that the US may be headed for a physician shortage, US healthcare leaders seemed to have completely forgotten that they had been equally panicked about a surplus just a few years earlier. With the announcement of another wave of health reform, the Affordable Care Act, whose provisions kicked in 2014, set off additional concerns about future need for physicians. A June 2010 AAMC report, for example, updated to take into account ACA provisions, projected a shortage of 91,500 physicians in 2020 and 130,600 in 2025. Jolly,

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473 Blumenthal, "New Steam for an Old Cauldron," 1782.
474 Ibid., 1783.
475 Ibid., 1783.
476 Ibid.,1782-1783.
477 Ibid., 1783.

Erikson and Garrision, writing in *Academic Medicine* in 2013 call this shortage "critical."[478] Meanwhile the 1997 cap on Medicare support for residency spots, that academic medicine had campaigned for just over a decade earlier, remains in place. Responding to health planning bodies' and organized medicine's calls to increase medical school enrollment, the 2007 medical school entering class was the largest in US history.[479] Although some programs felt they needed residents badly enough to create 6000 additional residency spots without Medicare support, as Traverso and McMahon note in *JAMA* in 2012, the GME cap and increasing US medical graduates have squeezed the numbers of IMGs down to 10-15% of US residents. If this squeeze continues, they argue, the result will be what the title of their article predicts, "Coming to American no more." Reiterating arguments familiar from past decades, Traverso and McMahon argue that the loss of IMGs will have unexpected effects for the US healthcare system. "Although many see this as a positive development (US programs have been accused of exacerbating brain drain from developing countries) this decrease may have additional unanticipated consequences for the diversity and activities of physicians practicing in the United States."[480] As IMGs essentially constitute much of the racial diversity within American medicine, they argue, reducing their numbers without attending to this issue would essentially whitewash medicine. Additionally, if practice patterns hold, a drop in IMGs would mean a corresponding drop in primary care physicians, a group disproportionately composed of IMGs, at a time when their supply is already critical. Other studies have also examined the questions of whether even greatly expanded

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[478] Jolly et al, "Participation in U.S. Graduate Medical Education," 2011.

[479] John K. Iglehart "Grassroots Activism and the Pursuit of an Expanded Physician Supply." *The New England Journal of Medicine* 358, no. 16 (April 17, 2008): 1741–49. 1741.

[480] Traverso and McMahon, "Coming to America No More," 2193.

number of USMGs would fill the critical roles IMGs have been serving as residents and beginning practitioners. Richards, Chou, and Sasso, for example, argue that expanding USMG supply has not so far resulted in many more physicians in New York health professional shortage areas.[481] Likewise a 2003 study found that 50% of the primary care physicians in rural Florida were foreign-born, and a 2006 study indicated that a shortage of providers willing to work in community health centers had been a challenge to expanding this program that often served the poor and underinsured. [482] [483] The ACA has also incited a different vein of concern, as one commentator argues, "US Healthcare Reform will extract an excruciating cost on the developing world."[484] With the increasing demand for physicians the act is predicted to create, fears that these clinicians will come from places that can ill afford to lose them have become part of the new rhetorical landscape of the IMG debate. As a historical examination demonstrates, however, this is not the first time such concerns have been raised and ultimately dealt with superficially and ineffectively. Part of the challenge has been the ambivalence of broader US discourses on immigration, on the one hand exclusionary, but on the other effectively embracing "brain drain" as a national policy since the 1960s, favoring immigrants with skills and professional backgrounds.

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[481] Michael R. Richards, Chiu-Fang Chou, and Anthony T. Lo Sasso. "Importing Medicine: A Look at Citizenship and Immigration Status for Graduating Residents in New York State from 1998 to 2007." *Medical Care Research and Review: MCRR* 66, no. 4 (August 2009): 472.

[482] Robert G. Brooks, Russell Mardon, and Art Clawson. "The Rural Physician Workforce in Florida: A Survey of US- and Foreign-Born Primary Care Physicians." *The Journal of Rural Health: Official Journal of the American Rural Health Association and the National Rural Health Care Association* 19, no. 4 (2003): 484.

[483] Roger A. Rosenblatt, C. Holly A. Andrilla, Thomas Curtin, and L. Gary Hart. "Shortages of Medical Personnel at Community Health Centers: Implications for Planned Expansion." *JAMA* 295, no. 9 (March 1, 2006): 1042.

[484] Kate Tulenko,. "Countries Without Doctors?" *Foreign Policy*, June 11, 2010. http://www.foreignpolicy.com/articles/2010/06/11/countries_without_doctors.

As Steven S. Mick argued to the COGME in 1996, "policy efforts over the past 50 years have had virtually no impact on the increase in supply of IMGs to the US."[485] Many of the physicians, statisticians, and policy makers involved in new 21st century debates about the role of internationally trained physicians in the United States often have a limited historical perspective on the issue. As selected examples from the 1940s, the 1970s, and the 1990s have demonstrated, however, a lack of awareness of historical trajectories, does not mean these decision makers are not affected by their legacy. Thus, in an odd way, it's not surprising that American medicine has lived the cliché—those who do not learn from history are doomed to repeat it. The periodic reemergence of the IMG debate is colored by the ethos of its times but brings up the same types of rhetoric and points to the same underlying, unresolved issues and persistent assumptions. Cumulatively, the effective policy approach to IMGs has been very different from any stated policy approaches in the past 60 years: Periods of relative tolerance and quiet recruitment interspersed with periods of vehemence, controversy and regulation has kept this group vulnerable, and thus one that could be drawn upon at will to fill gaps and mask deficiencies in an unstable, patchwork system. Without IMGs, it is very possible powerful interest groups in US healthcare such as organized medicine, medical educators, insurance providers, and hospitals, would have to admit and face the convenient inconsistencies in their policies and the ideologies that support them. Commentators who either defend IMGs as group valuable to the US for the service they provide or deride them as a menace to quality care and careful manpower planning both feed into this unsteady and perverse equilibrium. Beyond the rhetorical images crafted in these debates,

485 COGME, "International Medical Graduates," 25.

which often focus on IMGs as a proxy for more contentious root issues about the fundaments of the US healthcare system, however, are the complex stories of individual physicians who come to the US. These will be the focus of later chapters, chronicling the human dimension masked by these policy struggles. Likewise, this issue, often examined in a national context is in fact fundamentally an international one. Physicians migrate to the US in world where they often can and do chose to stay home or seek training in any number of nations. Likewise, just as the US imports healthcare workers, it also exports ideas, knowledge, and ideologies—these reciprocal processes will be examined in the following chapters as well.

Chapter 5: Health Worker Migration in International Historical Perspective: the Historical Legacies of Colonialism and American Foundation Development Work

INTRODUCTION

Although the previous chapters have examined the role of International Medical Graduates in the context of American medicine and the US health care system, a broader understanding requires a global perspective. Much scholarship on IMGs tends to be nation-centric, examining the roles of internationally trained physicians in the contexts into which they arrive. This bias in US medical and social science scholarship is apparent from the sources discussed in the previous chapters, but it is not limited to the US context, with major studies in the UK, New Zealand, and Canada for example, also using the country of arrival as the starting point. [486] [487] [488] This perspective can contribute to an overall myopia. The factors that bring physicians to train, work, and immigrate to the United States are tied into global structures both within and outside of medicine. Immigration scholars have recently called for "the need to study migration beyond the borders of nation-states and through the context of transnational and global processes,"[489] This chapter sees the migration of physicians to the United States as a part of complex global flows of skilled health care workers of all specialties, as part of dynamic global

[486] David Wright, Sasha Mullally, and Mary Colleen Cordukes. "'Worse than Being Married': The Exodus of British Doctors from the National Health Service to Canada, C. 1955-75." *Journal of the History of Medicine and Allied Sciences* 65, no. 4 (October 2010): 546.

[487] Marisa T. Gilles, John Wakerman, and Angela Durey. "'If It Wasn't for OTDs, There Would Be No AMS': Overseas-Trained Doctors Working in Rural and Remote Aboriginal Health Settings." *Australian Health Review: A Publication of the Australian Hospital Association* 32, no. 4 (November 2008): 655.

[488] J. Lister, "The Impact of Overseas Medical Graduates on Service and Training in the United Kingdom." *The New England Journal of Medicine* 315, no. 16 (October 16, 1986): 1038.

[489] Catherine Ceniza Choy, *Empire of Care*), 11.

migration flows more generally, and as a historically contingent phenomenon influenced by structures of economic power and inequality.

Not all physician and other health worker migrations flow from poor to rich countries, but overall, most do. Initially, physician migrations flowed along apparently long defunct colonial ties. Indian and Pakistani physicians, for example, began to migrate to the UK to fill the manpower needs of the NHS as early as the 1950s; likewise, Canada experienced an influx of British and also of South African physicians over the course of the mid-20th century. [490] [491] Perhaps most controversially, physicians and other health care workers in many nations in sub-Saharan Africa have been migrating to wealthy nations such as the UK and US even as their nation's health care systems struggle to provide the most basic services in the ongoing HIV pandemic. Filipino physicians and especially nurses, have been migrating to the United States since the early 20th century, but have since come to contribute to the health systems of places as disparate as Ireland and the Gulf States. [492] This is just one instance of how these flows have become increasingly complex. The Gulf States, for example, also attract physicians and nurses from much of the Islamic world, as well as South and Southeast Asia.[493] Geographer John Connell, in his survey of global health worker migration describes how these flows "first became important" in the 1960s.[494] In contrast to the circumstantial migration of European physicians during and after WW2, discussed earlier, the complexity of these flows belies an encompassing explanatory framework, as "over time, what

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[490] Emma L. Jones,, and Stephanie J. Snow. *Against the Odds: Black and Minority Ethnic Clinicians and Manchester, 1948 to 2009*. Manchester NHS Primary Care Trust, 2010.

[491] David Wright, Sasha Mullally, and Mary Colleen Cordukes. "'Worse than Being Married'" 546.

[492] John Connell, *Migration and the Globalization of Health Care*, 6.

[493] Ibid., 6.

[494] Ibid., 4.

were…relatively simple migration flows, usually reflecting linguistic, colonial, and post-colonial ties, became steadily more complex and more obviously perverse," drawing health care workers away from areas of greatest need, something he and his fellow health services scholars have termed the "inverse care law".[495]

Connell describes health worker migrations as a "seemingly inexorable…ever shifting carousel, that a century ago took missionaries to developing countries, [and] now draws health care workers from just those countries to richer counties."[496] This chapter will take a critical historical perspective on physician migration, tracing how development work by colonial powers and later US state and non-state actors, namely major philanthropic foundations, contributed to the pre-conditions for the mass health worker migrations of which the US IMG story is a part. As I will discuss, many of the ideologies identified in the previous chapters as shaping the US healthcare system's dysfunctional relationship with its internationally-educated physicians, have had broader global impacts on the processes that bring them to US shores.

This chapter will draw on two bodies of scholarship to contextualize these intertwined migrations and connect them to the IMG experiences discussed in later chapters. In the process I will contextualize the phenomenon of health worker migration within the lingering legacies of colonialism, the Cold War, and the advent of neoliberalism. I will begin with a survey of the relationship of medicine and colonialism. Then draw on scholarship on the roles of the "big three" foundations in shaping the structure and ideology of medicine, science, and the social context in which it is practiced both in the US and internationally. These philanthropic organizations, including the

[495]Ibid., 6.
[496]Ibid.

Carnegie, Ford and Rockefeller foundations, were founded in the US in the first half of the 20th century to supervise the distribution of the unprecedented fortunes of major American industrialists. The Rockefeller foundation, with its focus on medicine and public health, is particularly relevant to this discussion. The broader cultural strategies of these foundations and their vision for the role of higher education in development has been examined critically by historians, political scientists, and educators, focusing particularly on the Cold War context. A second body of literature, historical scholarship of medicine and public health, has examined the impact of the Rockefeller and Carnegie foundations, tracing how the beliefs and strategies of their founders continue to shape the worldviews of these disciplines, often in subtle but pervasive ways. This chapter will draw on both of these bodies of scholarship and connect them to questions social scientists and medical educators have been asking about physician migration; identifying historical factors that shaped a set of global systems and cultural logics that determine the origins and destinations of physician migrants as well as the growing perversity of these systems.

COLONIALISM AND *WESTERN, SCIENTIFIC* MEDICINE

Connell, in his 2010 survey of globalization and physician migration describes the 19th and early 20th century "humanitarian migration" of missionary physicians from European nations to colonized territories as the first modern mass migration of health care workers.[497] Furthermore, these missionary movements were often only a small part of the complex roles that Western medicine played in colonized territories. These contextually and historically contingent roles of Western medicine and Western

[497] Connell, *Migration and the Globalization of Healthcare*, 40.

education in colonial regimes shaped some of the pre-conditions of later mass migrations. As colonial regimes began to falter and then nominally end, these intellectual and structural legacies continued, setting the stage for how medical education would function in these "dependent nations," as well as for the role of non-state philanthropic foundations in this development.

The history of colonialism, medicine, and education is too extensive and varied to cover here. However, it is important to note that medicine played various pragmatic as well as symbolic functions in upholding colonial regimes as well as in movements of resistance to these empires. British- Iranian historian of medicine Hormoz Ebrahimejad argues that the history of "modern" medicine in non-Western countries has been monopolized by "the essentialist outlook in Western historiography," one that misconstrues both Western and non-Western bodies of medical knowledge as static ontological entities, with "Western," "modern," "scientific" medicine being transplanted wholesale to colonies and dependent states. In taking a "center-periphery diffusionist" approach, these histories have missed "the active involvement of local elements." [498] This denies the agency of academics, physicians, patients, and local and regional rulers in Non-Western countries during the colonial period, a period that coincidentally was also a time when Western notions of scientific medicine were themselves still taking shape.

Early implementation of Western medicine in colonial settings, for example in British Ceylon (Sri Lanka), was mainly focused on the health of European colonial administrators.[499] [500] Efforts to extend Western medicine more broadly, often through

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[498] Hormoz Ebrahimnejad, *The Development of Modern Medicine in Non-Western Countries: Historical Perspectives* (New York, NY: Taylor & Francis US, 2008), 1,4.

[499] Connell, *Migration and the Globalization of Healthcare,* 40.

preventive campaigns such as the Indian Medical Service, often served as "a form of social control," as much as health provision. [501] Toward the end of the 19th century, Western medicine in colonial settings expanded as it came to serve as a rhetorical tool of upholding colonial empires. To colonial administrators and well-meaning Western missionaries, health professionals and educators, making Western medicine available to local populations was an unquestioned benefit, alleviating suffering while demonstrating the benefits of Western civilization and values. As an American businessman in the Philippines wrote to President Woodrow Wilson, "through the ministrations of the doctor and the nurse, as well as the teacher…these people are being brought rapidly from head-hunting savages to useful and productive people."[502] George Vincent, representing the Rockefeller foundation in the Philippines, seconded this view, quipping "for the purposes of placating primitive and suspicious peoples with medicine has some advantage over machine guns."[503] Initially these values were propagated through care provision itself, for example in mission hospitals. Western physicians were at first reluctant to train local assistants in any formal way. Though some claimed this was because the racial and cultural inferiority of the locals prevented them from acting independently as medical professionals, many simply feared for their professional dominance. [504]

However, by the turn of the 20th century, newly established local training programs for less-prestigious but much needed roles such as health assistants and nurses, themselves became vehicles for overt and subtle promulgation of particular cultural

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[500] Soma Hewa, *Colonialism, Tropical Disease and Imperial Medicine*. (Lanham, MD: University Press of America 1995).

[501] Connell, *Migration and the Globalization of Health Care,* 40.

[502] Choy, *Empire of Care*, 15.

[503] Edward H. Berman, *Influence of the Carnegie, Ford, and Rockefeller Foundations on American Foreign Policy: The Ideology of Philanthropy* (Albany, NY: State University of New York Press, 1984), 26.

[504] Connell, *Migration and the Globalization of Health Care*, 51.

values. Catherine Ceniza Choy, in her history of Filipina-nurse migration to the United States argues that early nursing training programs established under the early 20th century American Colonial regime focused on values of science, service, and notions of hygiene, as "civilizing influences" on their nurse graduates. In addition to these overt values, she argues, these training programs also inscribed notions of class and race that continue to have an impact over a century later. According to Choy, "'Filipino health became a forceful metaphor for the primary objectives of US Colonialism," and thus so did American-established nursing and medical schools.[505] To American colonial administrators and health professionals, bringing scientific medicine and public health to the Philippines was crucial to transforming Filipinos from a "week and feeble race" to one eventually capable of self-government, reinscribing notions of racial hierarchy, the American self-image as a "benevolent" colonial power, and justifying American colonialism on the basis on poor native health. Using the writing of Lavinia Dock, an early American nursing reformer who wrote an early history of nursing in the Philippines as well as accounts left by Filipina students, Choy reconstructs some of the cultural stakes of early nursing education for the Filipina and American women alike.[506] Dock describes the struggle to recruit young women of "family [and] birth" from among the Philippine elites, describing with exasperation that to their families nursing appeared menial and the hospitals it took place in dirty and disreputable havens of last resort. She remarks with exasperation that students had to be taught "…the very A-B-Cs of hygiene

[505] Choy, *Empire of Care*, 21.
[506] Ibid.

and sanitation—rudimentary knowledge which, in our country, is assimilated we know not when or how—it is almost inborn." [507]

Yet, in the first decade of the 20th century, when Dock was writing her history, both professionalized nursing and scientific medicine had not yet become completely hegemonic in the US. The first American nursing schools were opened in 1873, representing the beginning of a struggle to professionalize nursing, which until that time, was viewed as menial work for low status individuals, much as it was to elite Filipino families. Furthermore, notions of hygiene based on the germ theory, which Dock contends was "almost innate" to American women had entered American consciousness less than 20 years before and were still far from common sense for many Americans. [508] Thus, Choy argues, these truth claims served primary cultural functions, legitimizing the colonial regime as working for the benefit of the colonized and reinforcing notions of Western cultural and racial superiority.

Choy's account of nursing in the Philippines is one example of how the pragmatics and ideologies of colonialism and medicine intersected. In other circumstances, under other colonial powers and with different local contingencies, these interactions and their enduring consequences, varied greatly. Though introduced by the colonialists, Western Medicine and its scientific claims to authority became a rhetorical and practical tool for local actors and movements of resistance. While American colonial administrators and health professionals used the claims of Western medical advancement to reinforce the legitimacy of their political and racial claims, anti-colonial regimes and elites often adopted these values as a form of resistance. Ebrahimnejad, for instance,

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[507] Ibid., 25.

[508] Nancy Tomes, *The Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge:MA: Harvard University Press, 1999).

claims that "the adoption of colonial science, particularly in countries under colonial domination, was often for the purposes of countering the Western political and military power."[509] "Science," pronounced the anti-Imperialist activist Seyed Jamal al-Din, "does not belong to the West or the East but to whoever acquires it."[510] Attributing the prosperity and power of Western nations to their advancements in science and technology, al-Din felt the possession of this knowledge was essential to Islamic nations resisting their encroachment.[511] Meiji Japan adopted just this approach, establishing research institutes and "modernizing" its medicine and science in order to be able to compete with Western powers.[512] Likewise, Indian reformers founded the "Indian Association for the Cultivation of Science," in 1876 in order to develop local participation in the rhetorical and practical value of science and technology.

These negotiations happened in different ways. For example, Mohammed 'Ali Pasha, who re-established local rule in Egypt after the expulsion of Napoleon, "was firmly determined to modernize his country, for which he fostered great ambitions of industrialization and territorial expansion."[513] He did so by pushing for industrialization, founding weapons making and textile industries. He accomplished many of these ambitions by importing Western experts to run the industries and train local professionals. His approach to medicine was analogous, engaging Western physicians on a sanitary board that directed plague quarantines, as well as inviting Antoine Barthelemy Clot to establish a French style medical school. In this historical instance, Mary Moulin

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509 Ebrahimnejad, *The Development of Modern Medicine*, 4.

510 Ibid, 4.

511 Ibrahim Kalin, "Sayyid Jamal al-Din Muhammad b. Safdar al-Afghani (1838-1897)" Center for Islamic Sciences, Accessed 12/21/2014, http://www.cis-ca.org/voices/a/afghni.htm.

512 Ebrahimnejad, *The Development of Modern Medicine,* 9.

513 Ibid, 43.

argues, Western medicine had a complex role in the geopolitics of the early 19th century, in this case serving the interests of a non-Western ruler.

Margaret Jones describes a different negotiation between colonialism, resistance, and medical systems in 19th and early 20th century Sri Lanka, then Ceylon. She chronicles the debate, beginning in the 1920s about the acceptance of Ayurvedic medicine into the government health care system. She notes the "interesting fact" that the Western practitioners who opposed these developments were in fact Ceylonese, physicians trained at the medical college established there in 1870. Meanwhile, the supporters for a greater role for Ayurveda were a motley coalition of British Colonials and Nationalist leaders. "This was a case," she argues, "of one section of Ceylonese elites opposing another…both groups were highly Westernized and subject to similar colonizing influences".[514] At stake, she explains, was the political support of the public which was decidedly pluralist in its medical preferences. Ultimately supporters of Ayurveda carved out a niche for the practice by assimilating the claims to authority Western practitioners themselves used: arguing that Western medicine did not have an exclusive claim in being scientific, and by establishing systems to professionalize and certify Ayurvedic practitioners. [515] The above examples, a century apart and centered in three very different contexts illustrate the complex web of meanings within which Western medical practice, knowledge, and education were entangled in the colonial context.

Although the role of Western medicine in colonial regimes resists easy classification, these examples emphasize some relevant commonalities. The first is the rhetorical role of science and technology, and the second is the roles of elites In turn of

514 Ibid., 114-115.
515 Ibid., 112.

the 20th century Philippines, early 20th century Sri Lanka, and 19th century Egypt, the identification of Western medicine with science and scientific practice served as a foundation for both the claims of colonial administrators and anti-colonial leaders. The relationship with science was essentially the truth claim of this system. Western medicine had value because it was epistemologically linked with a method and body of knowledge that had value in explaining the world and acting upon it. American nurses founding nursing education in the Philippines for example, saw science as the foundation for a more efficacious and beneficent nursing practice. Implicit in this perspective is the validation of the status of nursing as a profession and also of the political domination that brings these practices to colonized people. To Mohammad Ali Pasha, Western medicine was a part of a broader program of Westernization and the assumption he shared with many 19th century non-European leaders that assimilating the technologies and social structures of the West would allow them to hold their own against colonial incursion. To Sri Lankan nationalists, claiming a scientific basis for Indigenous medicine was a rhetorical tool for insecure port-colonial leaders to establish support from the broader population. Here it is valuable to revisit Ebrahimnejad's argument, that "Western," "Scientific," and "Modern" medicine are not always synonyms, and that "modern" medicine was constructed among contingent circumstances as much in places it was "imported to" as it was in the Western countries in which it originated.

FROM COLONIAL POWER TO US FOUNDATION HEGEMONY

As these analyses demonstrate, the Western, scientific medicine that was exported to these places on the "global periphery" was itself in flux during the 19th and 20th centuries. The function and ideology of "scientific medicine" became hegemonic in the West due to various contextual processes. In the United States, however, the roles of organized medicine and the Rockefeller and Carnegie foundations in the ascendancy of a certain vision of scientific medicine have gotten a great deal of attention from historians. We will now turn to a brief synopsis of this work as a transition to the next phase of this history: as the great colonial empires faltered after WWI and all but faded after WW2, American philanthropic foundations began to play a prominent role in the development of medical education in the late- and post-colonial world. The work of these foundations, I will argue, however intentionally, played a part in instituting the conditions for mass physician and other health worker migrations later in the 20th century.

According to historian Paul Starr, although the US medical establishment was to become a globally influential force for a particular vision of biomedicine by the mid-20th century, just 100 years earlier, the social and cultural authority of so called "allopathic" medicine, or its association with "scientific medicine" was hardly a given.[516] The history of the burgeoning of medicine and medical education in the United States since that time had been profoundly influenced by its negotiations with developing structures of capitalism, not just as an economic system, but as a way of life. Current discourses rarely acknowledge the complex, often contradictory relationship between capital and medicine in the United States and how the historical trajectory of this relationship has shaped

[516] Starr, *The Social Transformation of American Medicine*,81-102.

medicine from the late 19th century and into the 21st. These discourses also tend to focus on medicine as care delivery in the biomedical paradigm, missing the broader view of medicine as a system of relationships between medical education, biomedical research, and the delivery of care itself. A view of the role of Capital in medicine is anchored in scholarship on the large-scale corporate philanthropy that took shape in the late 19th century and reached its apex just before WW2.

Throughout the 19th century, medicine in the US was not necessarily a high status profession. Medical practice was competitive, uncertain, and fundamentally relied on physicians' negotiations with their clients. Hydropathy and homeopathy rivaled the status of more traditional "allopathic" medicine.[517] [518] Medical research was a luxury, even for the European-trained elite of the American medical profession.[519] Finally, medical education was dominated by for-profit institutions and was generally of uneven quality.[520]

Meanwhile, on the broader American social and political scene, the political and social foundations of American life were undergoing a tectonic shift. Historian William Applebaum Williams describes one of the many impacts of the Civil War, as the entry of United States into the age of industry and Capital. The Civil War, he argues "produced an industrial system rather than being fought with one."[521] The "ultimate victors of the war" were the corporations and the men who, for the most part, ruled the new economy it had made possible. Carnegie of US Steel as well as John Davison Rockefeller of

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[517] Starr, *The Social Transformation,* 81-102.

[518] Andrew Cunningham, and Perry Williams, eds. *The Laboratory Revolution in Medicine* (Cambridge, UK: Cambridge University Press, 2002), 130-131.

[519] Cunningham, *The Laboratory Revolution,* 130.

[520] Starr, *The Social Transformation,*118-119.

[521] Quoted in: E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America*. (Berkeley and Los Angeles, CA: University of California Press, 1981), 16.

Standard Oil came to exemplify the fantastically rich and influential "robber barons" that rose to prominence in the late 19th century. These men, their ruthless business practices, and the vast fortunes they accumulated were a new, and to many, very disturbing phenomenon in US society. Anxiety over this rapid industrialization and growing inequality contributed to what historian Richard Hofstader called the "psychic crisis" of the early 20th century. As political scientist Inderjeet Parmar argues, Rockefeller and Carnegie's empires were "implicated both in the sources of the psychic crisis…and in proposing how to address some of the symptoms of the crisis."[522] By the 1910's Both Rockefeller and Carnegie had inspired public controversy with their harsh treatment of labor. The Homestead strike of 1892 and the Ludlow Massacre of 1913 were the most prominent of several incidents that resulted in deadly violence.[523]

It was right about this time that Carnegie and Rockefeller both committed large amounts of their wealth to their eponymous foundations. Rockefeller began large scale charitable efforts in 1892, with the establishment of the University of Chicago, and added the Rockefeller institute for medical research in 1901 as well as the general education board in 1903. Carnegie began by funding a scientific research institute in 1902 and in 1905 founded the Carnegie institute for the advancement of teaching, among other philanthropic projects.[524]

It is easy to interpret Carnegie, Rockefeller, and their fellow gilded age robber barons' turn to philanthropy as a public relations move, or as a way to assuage guilty consciences. However, the critical perspective taken by scholars such as E. Richard

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[522] Inderjeet Parmar, *Foundations of the American Century: The Ford, Carnegie, and Rockefeller Foundations in the Rise of American Power* (New York, NY: Columbia University Press, 2012), 37.

[523] Parmar, *Foundations of the American Century*, 37-38.

[524] Ibid., 40.

Brown, Edward Berman, and Indarjeet Parmar in reassessing the historical trajectories of these foundations lays out a more nuanced and interesting perspective on the functions these foundations came to serve. These perspectives also help to explain why medicine and science were such major foci of these foundations' work from their founding. In tackling the question of the role of capital in the development of medical care, education and research in the United States, and later across the world, it is helpful to begin with a broad trajectory and a discussion of the role of ideology in corporate philanthropy.

According to Parmar, the Rockefellers and Carnegie saw themselves as "modernizing" charitable giving into "scientific philanthropy" and made a point of distinguishing the two. They came to see philanthropy as investment rather than simply giving, planning to "reap dividends in the form of social peace and stability, particular forms of progress, ideological legitimation of the American system, and ameliorative reform, making American modern through the rule of expertise…"[525] Much like their contemporaries in India, Egypt, and Sri Lanka, many American elites of the late 19th and early 20th centuries shared a deep belief in science, and saw its pragmatic and rhetorical power as means to achieve social and political goals.

Historian and public health scholar E. Richard Brown, in his controversial 1976 monograph interpreted the foundations' focus on science and medicine as an explicit and deliberate part of the Capitalist societal agenda. Brown quickly denies that he is implying that scientific medicine was implemented in some smoke-filled room conspiracy, rather insisting that the "robber barons" who established the agendas of these philanthropic organizations and the reformers they employed to help them spend their

[525] Ibid., 45.

money were true believers in Capitalism not just as an economic system but as a way of life, as well as in science as a way to uphold and enrich it.

The ideology of capitalism, as expressed by J.D. Rockefeller, Andrew Carnegie and others of their generation had complex roots. In the traditional Marxian definition, ideology upholds the interest of a societal ruling class as the common values of that society. Antonio Gramsci added the idea of hegemony— the process by which those whom this ideology actually exploits come to accept it was their own. In this view ideology can encompass anything from language, to religion, to art, and most importantly, things as subtle as the "common sense" of a culture. The worldview of the leading American capitalists of the turn of the 20th century was deeply tied to religious views. In Rockefeller's own words, "God gave me my money…I believe it is my duty to make money and still more money and to use the money I make for the good of my fellow man according to the dictates of my conscience."[526] The rationale of this argument was very similar to Carnegie's—God gave money to those who were meant to have it, these men by definition were best suited to know what to do with it for the common good.

Although Brown establishes that Rockefeller and Gates were true believers in their own ideology, he argues, they were not blind to the fact that not everybody was - to them that was one of the functions of philanthropy. The widespread strikes of the late 19th century and the public outcry against the gross economic inequality lead to a fear of unrest. Their response, he argues, was to institute programs that "did not suggest that the capitalist social system should be altered," but "rather…ameliorate the harsh conditions

[526] Brown, *Rockefeller Medicine Men*, 33.

of capitalism by helping individuals escape from its pits and lead both useful and more satisfying lives."[527] Rockefeller and Fredrick T. Gates, his philanthropic advisor, also thought bigger, however, focusing on "the future needs of their social system," and on the "training of personnel needed by industrial capitalism if it were to survive and grow."[528]

Brown insists that among this class of professionals, physicians had a special role to play. The ideology of the Progressive movement saw medicine as a public good, one that should be endowed for the good of society in some way. The philanthropic support of medicine made sense from the perspective of maintaining a healthy and productive workforce. Furthermore, the reductionist and scientific viewpoint that philanthropic money actively supported within medicine and public health served to medicalize what would otherwise be seen as social distress caused by an unjust system. A technocratic world where human problems could be predicted and addressed with the application of scientific knowledge was the dream of many progressive era reformers. Hence, medicine, as the queen of the human sciences, had a special function. Lily E. Kay, in her history of Rockefeller support for molecular biology argues, "During the Progressive era, science emerged as a symbol of reason and efficiency, the fountainhead of objective knowledge and industrial prowess."[529]

THE FLEXNER REPORT AS GAME PLAN FOR PHILANTHROPY AT HOME AND ABROAD

Brown uses the work of Abraham Flexner and his famous 1910 report as an example of how corporate ideologies helped shape American medicine through the roles of the foundations. The Flexner report, discussed in greater detail in chapter two,

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527 Ibid., 23.

528 Ibid.

529 Lily E. Kay, *The Molecular Vision of Life: Caltech, the Rockefeller Foundation, and the Rise of the New Biology*. (New York, NY: Oxford University Press, USA, 1996), 24.

commissioned by the Carnegie foundation, established principles for American medical education taken as gospel for over a century. Among them was an emphasis on laboratory science, research, and the cultivation of physician scientist-technicians.

Although the influence of the Flexner report on medical education may have been exaggerated, perhaps the real historical significance of the bulletin was that it served as a game-plan for corporate philanthropy. In keeping with Flexner's vision, the Carnegie and especially the Rockefeller foundation, of which Flexner became a trustee soon afterward, aimed to "make the peaks higher," rather than distribute their wealth evenly among existing medical schools. Over the next few decades the foundations "proceeded by funding the strongest institutions while using them as the standard with which to evaluate all others."[530] Historian of medical education Kenneth Ludmerer, argues that these reforms did indeed have their intended effects on the quality of graduates, as they came to "embod[y] both "the achievements of scientific medicine…and the narrowness of vision of scientific medical education"[531] The educational system outlined by Flexner's program, established by the elite within the medical profession, and deeply shaped and reinforced by corporate philanthropic contributions has kept its basic structure for over a century.

Likewise, critiques leveled at this new approach to medical education at the time also continue to be relevant. As these reform strategies were transplanted, often wholesale to other cultural contexts by philanthropic efforts, the weaknesses often accompanied the benefits. These reforms were very much to the detriment of the development of minority and women's health, and created a problem of imbalance

530 Elizabeth Fee, *Disease and Discovery: A History of the Johns Hopkins School of Hygiene and Public Health, 1916-1939* (Baltimore, MD: The Johns Hopkins University Press, 1987), 4-5.

531 Ludmerer, *Time to Heal*, 25.

between urban and rural care. The efforts by foundations to "make the peaks higher," generally meant that rural areas, previously well supplied with medical schools and medical men and women under the for-profit system wound up in deeper and deeper valleys. The increased cost of the new, higher quality medical education resulted in fewer students choosing less profitable rural practices upon graduation. As Ludmerer details, medical schools often had explicit quotas for Jews and women, and the rising costs of this better quality medical education and limited availability of scholarship money effectively limited students from poor, minority, or rural backgrounds. Disparities in minority and women providers, in turn, have been blamed at least partly for disparities in care of these populations. This new scientific education also emphasized a reductionist, fundamentally biological view of people's problems, revealing a systemic, and as some have argued, deliberate, blindness toward the social determinants of health medical reformers have been struggling with ever since. In this new model of medical training students learned to see sick people in a hospital setting, away from their homes, families and social contexts. As early as 1927, medical educator Francis Peabody argued that "young graduates…are too 'scientific' and do not know how to take care of patients."[532] As the foundations expanded their approach to medical education into their international work, many of the faults of the system were transplanted with it.

AMERICAN PHILANTHROPIC FOUNDATION IDEOLOGY AS TIME-AND CONTEXT- BOUND ASSEMBLAGE

Compared to Brown's radical and somewhat blunt critique of philanthropic foundations as purveyors of capitalist ideology in American medicine, Paul Starr takes a

[532] Francis Weld Peabody, "The Care of the Patient." *Journal of the American Medical Association* 88, no. 12 (March 19, 1927): 877–882.

less extreme Marxian perspective, voicing some common concerns with Brown's interpretation. "The legitimacy of capitalism," he argues, "rested on more ample foundations than the alleged ideological functions of medicine in focusing attention on bacteria rather than class interests."[533] Scientific medicine, after all, had champions among socialists and communists as well and also triumphed in socialized states. As discussed above in the case studies of scientific medicine in the colonial context, elite faith in the power of science to create solutions was by far not limited to the American context. Scientific medicine and its relationship to the nascent Capitalist system in the United States reflected a time and context-bound assemblage—a sort of snapshot of how disparate social and political forces have come together. There are many permutations of how science, medicine, and Capitalism might have interfaced, but in the United States at the turn of the 20th century, they did so in a very particular and powerful way through the great foundations. As the United States gained in global influence in the years leading up to and after WW2, this particular coalescence of truth, ideology, and power was to have an increasingly global influence. As the foundations turned their philanthropic attentions toward global populations, the logics their leaders used in developing interventions were largely circumscribed by the common sense (in the Gramcian sense) they had developed in the American context. Rockefeller foundation leaders, especially at the outset of their work abroad in the 1910s and 20s largely applied a bluntly biological lens to the health problems of the countries they worked in. They also brought a distinctly Flexnerian perspective to their interventions in health worker professionalization and medical education. As William H. Schneider states in his introduction to a scholarly compendium

[533] Starr, *The Social Transformation*, 228.

examining Rockefeller support for European medical education and research, it is important not to overestimate the overall influence of the Rockefeller and other foundations. They were, after all, only one set of players in multiple, diverse and dynamic contexts.[534] However, the time, money and attention Rockefeller foundation functionaries devoted to health interventions and medical education in the developing world was considerable, both in its own right, and as a model for later state policies; thus, as I will argue, significant in shaping the circumstances of health worker migrations that continue into the 21st century.

THE FOUNDATIONS' IDEOLOGY AND THE TURN TO GLOBAL HEALTH:

Shortly after their inception, the Carnegie and Rockefeller foundations expanded beyond domestic projects, intervening for "the well-being of mankind," in places as disparate as Canada, China, Sri Lanka, Brazil, France and parts of Africa.[535] [536] The focus of these interventions were mainly medical, following Gates's moto, "disease is the supreme ill of human life, it is the main source of almost all other human ills—poverty, crime, ignorance, vice, inefficiency, hereditary taint, and many other ills."[537] John Farley, in his history of the Rockefeller foundation's International Health Division, founded in 1913, described the division leaders' "totally biomedical view of public health," one "from which they rarely diverged" as simultaneously the organization's greatest strength

[534] William H. Schneider, *Rockefeller Philanthropy and Modern Biomedicine: International Initiatives from World War I to the Cold War* (Bloomington, IN: Indiana University Press, 2002), 1-3.

[535] Berman, *Influence of the Carnegie, Ford, and Rockefeller Foundations*, 1984.

[536] Ibid.

[537] Mary Brown Bullock, *The Oil Prince's Legacy: Rockefeller Philanthropy in China* (Stanford, CA: Stanford University Press, 2011), 19.

and most limiting weakness.[538] Although there were some notable exceptions to this view, for example John Black Grant, self-described "Rockefeller Bolshevik" and advocate for social medicine in China and India, the division pursued an approach focused on eliminating particular diseases from the regions they worked in[539]. While focused on mosquito control in Brazil and hookworm treatment in Sri Lanka, as Farley, along with other scholars demonstrate, Rockefeller representatives to a large extent missed the overarching social and demographic conditions that contribute to the waxing and waning of these diseases, such as migrations, famines, and the mal-treatment of plantation workers.[540] Farley attributes this to the technical background of many of the foundation leaders, arguing that as physicians and scientists, they were not attuned to see beyond their own expertise.

Although his evidence actually supports many of their arguments, Farley takes a skeptical view of what he dubs the "new and hard-edged ideologically driven historians," who describe the International health division's work as a "diabolical plot" to further the ends of American capitalism.[541] In his critique of E. Richard Brown and other critical historians such as Soma Hewa, Farley argues that he finds no evidence in his archival work that "public health operations of the Health Division were in other words, a series of covert operations…" by which American Capitalists "attempted to develop and control the market and resources of foreign countries in order to enhance profits" of their business ventures.[542]"On the contrary," he continues, "what the Health Division's

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538 John Farley, *To Cast Out Disease: A History of the International Health Division of Rockefeller Foundation* (New York: Oxford University Press, 2003,) 6.

539 Ibid., 14.

540 Ibid., 290.

541 Ibid., 292.

542 Ibid., 292.

archives indicate to me is an organization with its sights fixed on narrow medical concerns." In the personal papers of its leaders "it is a surprise to find political or social commentary on the countries they worked in."[543] Although he recognizes that "'the medicalization of public health,' certainly resulted in the avoidance of those social and economic ills which are the natural outcome of unbridled capitalism," thus to some extent avoiding calls for "the reconstitution of society,"[544] he also remains unconvinced that Rockefeller physicians and scientists were" mere tools" of the Rockefeller family, or "ideologues for capitalist society."[545]

Farley's response to these critical historians, however, misses the nuances of their arguments. Rockefeller foundation scientists and administrators were not tools of their funders or backroom conspirators, but true believers in the value of the social projects they supported. Farley correctly emphasizes the deliberately apolitical stances of the physicians, administrators and scientists of the International Health Board, something that in and of itself is worth examining from the point of view of ideology. As leaders of their fields, foundation functionaries embodied ideas of expertise emblematic of the Progressive era. Experts were highly educated, scientifically minded individuals who approached problems technically and dispassionately. As discussed above, these experts partook of the dream that social problems could be addressed with careful study and intervention. The physicians and public health experts of the International Health Board embraced this ideal of expertise and constructed their project as a technical rather than an ideological one. In an era obsessed by efficiency and the power of science as a force for progress, such a view was common sense, especially to those experts. These individuals,

[543] Ibid., 294.
[544] Ibid., 296.
[545] Ibid., 296.

at least initially, saw disease as the root rather than the consequence of social problems, and had a deep "faith that technology and managerial rationality [could] solve a host of problems." [546] These deeply held assumptions put an unmistakable stamp on future international medical education projects undertaken by the foundation.

As Edward Berman, one of Farley's "diabolical plot" historians puts it, "The commonality of outlook that lead the foundations to undertake certain programs at home and abroad …does not necessarily imply an active conspiracy…High ranking officials did not gather in a New York or Washington office to devise programs ostensibly designed to link Africans, Asians, and Latin Americans to the world capitalist economy."[547] There was no need for such a conspiracy because foundation leaders, often men from similar backgrounds (typically white, protestant, business and civic leaders from the East Coast), shared many of the same values and notions of truth.[548] Their philanthropic goals and the means to achieve them were animated by a powerful shared notion of common sense. As the foundations began to define their roles in international work in the first half of the 20th century, yet another unifying truth was the linkage between capitalism, American values, and the US's growing power in the world.

The Foundations' international work often began with pilot projects closer to home. In the case of medical and other health professional school development this framework was laid by contributions to certain programs and strategies at institutions like Johns Hopkins. On the one hand, projects supporting higher education were focused on elite building. Rockefeller's own rationale for establishing the University of Chicago, for example, was to create graduates that would "spread their culture far and wide," drawing

546 Berman, *Influence of the Carnegie, Ford, and Rockefeller Foundations,* 163.
547 Ibid., 26.
548 Ibid.

on notions of what would come to be called "human capital."[549] This attitude is also apparent in the Rockefeller foundation's approach to supporting medical education. An approach focused on "making the peaks higher" resulted in a support only to institutions that were deemed to be the leaders in their fields. Rockefeller foundation advisor Timothy Richards, for example, re-iterated this emphasis, critiquing more traditional charitable work such as missionary schools: "to pursue further the task of educating from the bottom up is foolish in the extreme. Education at the top, the very top, and the rest will take care of itself. The highly educated will educate those a little lower down, those still further down and so on."[550] Flexner, Gates and their fellow trustees articulated an almost unshakable faith that this approach would in fact bring up the overall quality of medical education.

These strategies in educational development and public health initiated in the American South were often transplanted wholesale to the international work the foundations were soon to undertake, and with them came the logics and values embedded by their founding consensus. As Mary Brown Bullock puts it, "the [Rockefeller] foundation used the ideologies of American science and medicine as a template for its engagement with countries as different as the United Kingdom and Ceylon."[551] In 1913, just three years after the Flexner report and with their public health work in the South just getting underway, Rockefeller leaders at all levels were already thinking internationally.[552] Hookworm eradication projects were rapidly extended to British Guiana, Brazil, parts of the Caribbean, and British Ceylon, among other places. Around

549 Parmar, *Foundations of the American Century*, 13.
550 Bullock, *The Oil Prince's Legacy*, 18.
551 Ibid., 3.
552 Farley, *To Cast Out Disease*, 65.

the same time, foundation leaders, including John D. Rockefellers Sr. and Jr., were looking to expand support for medical education and research. One of the major foci of Rockefeller philanthropy was the Peking Union Medical College, an institution built to become "the John's Hopkins of China."[553] This project, discussed in more detail later, was the largest and perhaps best studied of several attempts to build the "John's Hopkins of" in different parts of the world. Areas of interest to Rockefeller public health ventures also became the foci of various educational projects, aiming to train the local nursing and public health workforce. In the Philippines for example, the foundation sponsored nursing graduates to come to the US for training. Brazil was also the focus of Rockefeller efforts to establish both an American style nursing school and a major public health research and training institute.[554] Even places like France, England, and Canada, with a much longer history of scientific medical education than the United States, became the sites of major Rockefeller medical and public health educational development projects. Although the foundation's medical and public health work will be the focus of this discussion, it is also important to keep it in context of overall Rockefeller and other foundation activities and goals. As we will see, Rockefeller medical work abroad demonstrated and promoted the same deep faith in science and technology and approach to elite building. Although these goals and assumptions evolved between the 1910s and the Cold War, the overarching aims remained the spread of Western medicine as a vehicle for Western and more specifically American culture and cosmopolitan values, as well as a general humanitarian view that this was a helpful thing. As Bullock puts it "the first Rockefeller advisers believed that the transmittal of Western scientific values would

553 Bullock, *The Oil Prince's Legacy*, 18.
554 Farley, *To Cast Out Disease*, 203-216.

lead to shared cultural and political norms." Most importantly, early foundation approaches to development became a blue print for future interventions by governments and international agencies.[555] Some of the built-in assumptions and prejudices of this approach, however, had unintended consequences. Just as the Flexnerian elite-building approach had unintended consequences for the doctor-patient relationship as well as for rural and minority health in the United States, many of these same effects were reconstituted in areas it was exported to. There were additional unintended consequences, however, including a shaping of the circumstances that contribute to contemporary rationales and patterns of physician migration.

CHINA AND THAILAND: CASE STUDIES OF HOW FOUNDATION ASSUMPTIONS SHAPED MEDICAL EDUCATION ABROAD

The history of the Peking Union Medical College offers some insight into the worldview of foundation trustees as they chose to devote significant resources to the creation and support of elite scientific medical institutions in poor and post-colonial areas across the globe. Although public health work was a major focus of Rockefeller efforts—94 million dollars between 1911 and 1951, resources devoted to elite medical institution building were administered separately, and were relatively greater—44 million in the same period was devoted to developing one institution in China alone.[556] Historian Mary Brown Bullock has devoted a significant portion of her career to studying the relationship between Rockefeller philanthropy and the PUMC. Publishing her first study, *An American Transplant: The Rockefeller Foundation and Peking Union Medical College* in 1980, she revisits the subject from the vastly different political context of 2011 in her

[555] Bullock, *The Oil Prince's Legacy,* 4.
[556] Ibid., 19.

book *The Oil Prince's Legacy: Rockefeller Philanthropy in China*. While her initial study described the PUMC as an ultimately failed effort—one that had no future after 30 years of communist rule in China, her revised history describes the lasting impact of Rockefeller philanthropy 100 years after the fact. For her, Rockefeller foundation involvement in China began with the Rockefeller family's personal and business interests. Indeed the PUMC, funded by the China Medical Board, a subdivision of the Rockefeller foundation, received a disproportionate level of attention from the Rockefellers themselves. John D. Rockefeller Jr. personally visited the university and was involved in every stage of its development from its conception. The PUMC, like Johns Hopkins and other flagship institutions that the foundation supported in the US, was squarely built on the "educate at the top" style of institution building. [557] Advised by Abraham Flexner, William Welsh, and the presidents of Harvard and the University of Chicago, the Board's goal was to, in John D Rockefeller Jr's own words, "to develop in China a medical school and hospital of a standard comparable with that of leading institutions known to Western civilization."[558] Instruction at the school was in English, and a large American-style teaching hospital was constructed on the campus. Many of the university's graduates were sent to leading institutions in the US on fellowships for further study, with their powerful supporters opening doors normally closed to Asians in a time of strong anti-Chinese prejudice.

Although the first generation of faculty were American or American trained Chinese, the founders hoped PUMC's own graduates would gradually come to occupy most of the teaching and research posts. While the best students would remain at PUMC,

[557] Ibid., 21.
[558] Ibid., 44.

the hope was, others would spread out throughout China, building high caliber scientific medical schools and training a cadre of Western physicians to fulfill China's needs.[559] However, this strategy was geared at more than the spread of Western medicine. It also aimed to inculcate broader Western values as well—building networks between Chinese and American thought leaders. According to NGO scholar Quisha Ma, Rockefeller trustees "envisioned the values and methods of science taking deep root in China and giving rise to a new worldview compatible with that of the industrialized West." [560] They felt science would "withdraw the Oriental mind" from "intuition and meditation," and replace it with "the Baconian philosophy from which modern life has sprung."[561] The goal, essentially, was to "convince Chinese intellectuals of the superiority of Western civilization."[562]

Like the American institutions it was modeled on, the PUMC emphasized curative medicine and state of the art research rather than public health and social impact. As Bullock argues, there were "definite contradictions," in "using an American model of medical education in a poor, developing country like China."[563] And, one could argue, similar contradictions in many parts of the still developing United States at that time. As Bullock ultimately asserts, by some of the founders' standards, however, the PUMC was a resounding success. By "nurture[ing] a tradition of professional relationships that survived even the upheavals of Mao Zedong's era," the PUMC played a role in creating and supporting a Western-oriented elite in China. In its early years, the university did

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559 Ibid., 33.

560 Quisha.Ma, "The Peking Union Medical College and the Rockefeller Foundation's Medical Programs in China," In *Rockefeller Philanthropy and Modern Biomedicine: International Initiatives from World War I to the Cold War*, ed. William Schneider (Bloomington, IN: Indiana University Press, 2002), 167.

561 Ma, "The Peking Union Medical College," 165-166.

562 Ibid., 168.

563 Bullock, *The Oil Prince's Legacy,* 33.

indeed draw important support from China's nascent nationalist elite. With the fall of the Quing dynasty in 1905 the Rockefeller foundation's promise of scientific modernization was a "match for 20th century China's culture and ambitions."

Early Rockefeller foundation work focused on this seemingly limited, and in many ways quixotic project, has never the less had an indelible impact on the shape of modern medicine in China as well as on Sino-American relations. Bullock asserts that the American-educated Chinese scholars who dominate that country's scientific elite to this day are a legacy of the institution building work of the Rockefeller foundation that began a century ago.[564] As Parmar argues in his broader study of American foundation work across disciplines, network building was the true success, and also the true aim of most foundation programs. Early Rockefeller foundation work in China and elsewhere was a blueprint not just for the Rockefeller foundation but Ford, Carnegie, and multiple smaller foundations' work throughout the 20th century. The goal of creating "a critical mass" of scholars and experts in a given region was ostensibly intended to aid development. Even foundations' own assessments, however, admitted that this rarely happened. All too often, third world universities were found to be "dysfunctional and disoriented," through the "adoption of American and other Western university structures 'with little thought to how this mode of academic organization would fit to serve existing conditions."[565] Scholars at these universities, in turn, become closer with the global networks they participate in than their local contexts—becoming abstracted from the work international support ostensibly wants them to do.

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564 Ibid., 1.

565 Parmar, *Foundations of the American Century,* 13.

The conflict between local needs and international prestige has been a factor in foundation-supported institutions of higher learning across time and place. At best, the process becomes a negotiation, especially when strong local voices intervene to shape what foundation work looks like in their countries. Yet who these local voices represent is itself a complex question. In China, for example, Rockefeller foundation efforts appealed to the country's small, already Westernizing elite, who to some extent shared the worldviews and assumptions of Western educators. As the examples that open this chapter demonstrate, in the 19th and early 20th centuries, notions about scientific education and progress became deeply entangled with discourses of nation building. Sociologists and Public Health historians Goldstein and Donaldson, in an older, though prescient paper, undertook another case study on the long-term impact of American foundation development efforts on the shape of medical education in a particular country. Focusing on Thailand, they use archival documents and what at the time was a nascent critical scholarship on professionalization to analyze the development of the Thai medical profession. Writing in the late 1970s, they describe an "inappropriate fit between the medical system and the needs of the country."[566] In so doing they invoke a concept Connell also draws on extensively, "the inverse care law," a situation where "the availability of good medical care tends to vary inversely with the need for it in the population served."[567] Per Goldstein and Donaldson, in the late 1970s Thailand suffered from a huge rural-urban maldistribution of physicians, with 70% of physicians located in Bangkok, a city home to less than 10% of the population (to some extent this problem persists today). Public health and rural hospitals were massively understaffed, with

[566] Michael S. Goldstein, and Peter J. Donaldson. "Exporting Professionalism: A Case Study of Medical Education." *Journal of Health and Social Behavior* 20, no. 4 (December 1, 1979): 324.

[567] Hart quoted in Connell, *Migration and the Globalization of Health Care*, 9.

physician patient ratios of 1/100,000 in rural areas vs. 1/1000 in urban locations.[568] The disease burden, furthermore, was mainly infectious diseases such as malaria, childhood gastroenteritis and other public health concerns.[569]

Essentially Goldstein and Donaldson argue that Thailand has suffered medical underdevelopment not despite Western intervention, but to a great extent because of it. Tracing the involvement of the Rockefeller foundation in Thailand in the 1920s and again in the 1960s, they describe how the introduction of Western medicine in Thailand was accompanied by powerful notions of Western professionalism which have turned out to be "ill-suited to handling the health problems of rural, poor, developing nations like Thailand."[570] In response to an appeal for help from the Thai government in 1921, as well as to a concern that "sanitation and public health are being advocated and introduced…WITHOUT DOCTORS," Rockefeller officials drew up a plan very much in keeping with their strategies both within the US and in other developing nations.[571] Referencing the Flexner report's grading of American medical schools, they were interested in building "a 'Class A' School with proper entrance requirements…to supply a small number of well-qualified medical practitioners who will act as leaders in important positions."[572] Although Rockefeller Foundation leaders suggested the Thai government institute a lower level paraprofessional school, they made it clear that they would not fund it, and the school never materialized. Furthermore as a condition of disbursing funding, the foundation insisted on an American dean for the medical school and new restrictive licensing laws that would exclude many older practitioners. These

[568] Goldstein and Donaldson, "Exporting Professionalism," 324.
[569] Ibid., 324.
[570] Ibid., 331.
[571] Barnes quoted in Ibid., 326.
[572] Pearce quoted in Ibid., 326.

choices, made in 1921, Goldstein and Donaldson argue, have made a lasting imprint on Thai health service provision. Like in China, instruction was in English, and the emphasis was on basic science research. Shriraj medical school indeed produced many "world class" physicians, but not nearly enough to fulfill Thailand's needs. Furthermore, these physicians were ill trained to address the health needs of a developing country. The new medical school's curriculum placed very little emphasis on public health or rural health although these skills were crucial to both the country's needs and the jobs available. According to Rockefeller foundation's own report, 50 percent of jobs available for graduates were in government service in the field of public health. This apparently deliberate de-emphasis of public health and national humanitarian needs became somewhat contentious even among Rockefeller foundation leaders, with John Grant of the public health division describing the policy as "something like putting up a building and leaving off the roof."[573] This criticism was countered by the American dean of Shriraj medical school, who argued that public health and preventive care would not serve the rhetorical function of "selling" Western medicine to the Thai population, instead insisting on the efficacy of dramatic curative intervention.[574]

Goldstein and Donaldson identify the "clinical mentality" instilled in Thai medical students by their Western medical education as a fundamental barrier to their social awareness. Drawing on Elliot Friedsen's definition of professionalism, they argue that the "clinical mentality" of professionals is "marked by a strong sense of individualistic responsibility." Thus, practitioners take on responsibilities for clients and

[573] Ibid.
[574] Ibid., 332.

peers, but have "little sense of responsibility to the larger community."[575] Through these attitudes, curative interventions such as surgery are privileged over large scale preventive measures or education in public health.

As in China, Rockefeller experts and educators came in with the best of intentions but were limited by their own assumptions and worldviews. A profound belief in expertise and science re-enforced an "educate from the top" philosophy that was supposed to have trickle-down effects on the whole society. Dean Ellis's emphasis on dramatic, curative interventions is indicative of at least a partial intent to use science and medicine as a rhetorical tool, introducing the benefits of Westernization. In some ways, Rockefeller philanthropy was remarkably successful in its goals, building a system of medical education and scholarly networks that continue to function. In other ways, however, these interventions have had unintended effects. The American medical education exported to Thailand reproduced the problems as well as the successes of American medicine. As contemporary critics were beginning to note even in the 1920s, the Flexnerian model of medical education produced a rural-urban mal-distribution of physicians, with many practitioners choosing to practice in cities where they could recoup the high cost of their medical educations, continue to follow contemporary developments in their fields, and find clients who could afford the high-technology interventions they were trained in. Likewise, post-Flexnerian educational strategies have tended to define medicine and public health as separate fields of expertise. As historian Elizabeth Fee argues, public health became "the weaker partner in an uneasy marriage," garnering relatively less attention and resources.[576] This was reflected in the structure of

[575] Ibid., 331.
[576] Fee, *Disease and Discovery*, 2.

Rockefeller philanthropies themselves. Although the foundation was one of the strongest champions of public health work, its divisions of public health and medical education were administratively separate, with a disproportionate share of resources going to curative medical education. Furthermore, as critics have noted, the brand of public health promoted by Rockefeller administrators was highly quantitative and laboratory based, with little room for exploration of social, community and demographic factors. These problems became particularly acute in a resource limited, developing world setting, which lacked strong local voices to advocate for community needs.

As Goldstein and Donaldson point out, these systematic blind spots in Rockefeller medical education's philosophy provided Thai medical students with an education that could not help them address local problems. Through their educations, however, many Thai medical students came to feel closer ideologically and even socially with medicine and with the West than with their own contexts. Paradoxically this was both an intended and unintended consequence for American medical educators working on these development projects. The first generation of Rockefeller philanthropists and the physicians intended to train medical students in both developed and developing countries to be members of an international community of scientists, however, they deeply believed that their emphasis on elite training would have society-wide effects. Educating at the top, according to their notions, would naturally prepare leaders capable of the rational dissemination of that knowledge. These assumptions systematically excluded social context, however, not accounting for the structural contingencies of local environments. In many cases, these star graduates were not given the fundamental tools or outlook they needed to make change. Like the fading colonial regimes they worked with, foundation

emissaries also targeted their educational efforts to high status or elite members of the societies they sought to impact. This was true both in China and in Thailand (where 90% of medical students were identified as having an elite background).[577] Thus they targeted a group that was more likely to have a pre-existing Westward- outlook, and less likely to come in with an awareness of the needs of ordinary people of their country. As Parmar argues, the elite-building strategies of foundations' educational work in a number of academic fields contributed to a "placelessness," where these local elites' "logic becomes increasingly divorced from their local culture and preoccupations."[578]

THE BIND OF ELITE GRADUATES: A CASE STUDY FROM PAKISTAN

Shafquat and Zaidi, writing in the New England Journal of Medicine in 2007, bring the global medical community's attention to the somewhat paradoxical role of Aga Khan University, established in Pakistan in 1983 as well as the quandaries its graduates face as physicians, researchers, and citizens, which echo those of Chinese, Thai, and numerous other physicians educated at Western-style elite institutions in the "developing" world over the past century.[579] Widely recognized as the leading medical training center in Pakistan, the university bills itself as, "competitive internationally in a number of research areas," a place where "faculty, students and staff are devoted to the highest standard of education, scholarship, research, and patient care." Furthermore, the university's own website demonstrates a conscious awareness of its development role, claiming, "[we] educate students to better understand local health care challenges in the

[577] Goldstein and Donaldson, "Exporting Professionalism," 329.

[578] Parmar, *Foundation of the American Century*, 8.

[579] Saad Shafqat and Anita K M Zaidi. "Pakistani Physicians and the Repatriation Equation." *The New England Journal of Medicine* 356, no. 5 (February 1, 2007): 442.

developing world and positively advance public health-care policy in response."[580] Shafquat and Zaidi, however, attest to a more complex reality. In 2004, of AKU's 1100 graduates 900 pursued graduate medical training in the United States. Of approximately 10,000 Pakistani physicians who have sought US training, only around 300 have returned home, of those 300, 40 teach on AKU's faculty.[581]

Aga Khan University, like many elite Universities in poor and middle income countries was founded on familiar principles, to train world-class professionals so they can become agents of development in their own nations. In this strategy, much like the US foundation-supported efforts that formed the model and strategies on which it was constructed, the university has been paradoxically both incredibly successful and has fallen short of the mark.[582] The University's graduates are indeed high achievers. Although motives for pursing medical education vary, as Shafquat and Zaidi attest, and as published and oral history sources citied elsewhere in this dissertation confirm, at least some contingent of these graduates truly desire to help the people of their countries. Shafquat and Zaidi present that problem as one of larger structural issues. Although Pakistani physicians hope to return from training abroad and use their advanced skillsets to make change at home, they often recognize that they will have to "negotiate local

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580 "Aga Khan Univeristy: Medicine." Accessed July 19, 2015. http://www.aku.edu/collegesschoolsandinstitutes/medicine/Pages/home.aspx.

581 Shafquat and Zaidi, "Pakistani Physicians," 442.

582 Aga Khan University itself had a history entangled in complex and unexpected ways with the histories of colonialism and development philosophies related earlier in this chapter. Supported by the Aga Khan foundation, the University, with sister institutions in Central Asia and Africa, was founded as a part of the foundation's larger global development strategy. This foundation, tied to the Aga Khan development network, is headed by the Aga Khan, the Imam of the Shia Ismaili Muslim sect. Descended from generations of spiritual leaders, the Aga Khan is also Harvard educated, and his biography on the foundation's website lists the elite American universities his family have attended. The website also presents the foundation's development work, heavily emphasizing a cosmopolitan, transnational strategy of supporting higher education, the preservation of classical Muslim scholarly and artistic traditions with the aim of being "the inspiration for Muslims to conceive a truly modern and dynamic society, without affecting the fundamental concepts of Islam." This history, worthy of further study and a dissertation all its own, could be an interesting example of the ways notions of truth and strategies of cultural hegemony associated with American soft power and nation building are in fact tools of many possible ends and worldviews.

circumstances for which they are unprepared: exhausting clinical demands, an impoverished population, an environment in which malnutrition is a significant cause of death, collapsed health care delivery systems, and patients who respond to an unjust society with mistrust."[583]

Shafquat and Zaidi present a seemingly contradictory solution to the quandary of elite medical and other academic institutions in resource-poor environments. "The answer," they argue, "is not to lament the irrelevance of these institutions but to advocate for more — for they can attract back highly trained professionals who have the potential to assume leadership roles."[584] In the following chapter of this dissertation I will continue to examine larger structures that lead physicians to feeling irrelevant and abstracted from their home environments even as they hope to be agents of change, relying on the voices of migrant physicians themselves in chapters seven and eight to describe what this experience is like.

[583] Shafquat and Zaidi, "Pakistani Physicians," 422.
[584] Ibid, 443.

Chapter 6: The Legacies of Development: Physician Migration Post World War Two

FOUNDATION IDEOLOGIES SHAPE TRANSNATIONAL DEVELOPMENT PHILOSOPHIES POST WORLD WAR TWO

By the late 1920s, a combination of younger leadership and disillusionment with existing strategies led to a modification in approaches to development among Rockefeller foundation trustees.[585] Although this new group demonstrated a more humanitarian interest in population health and placed value on public and community health, some fundamental aspects of the foundation's founder's attitudes lived on. In China, younger trustees questioned whether it was appropriate to invest so heavily in one high tech medical school, when that money could be more directly applied in public health work. In fact, China's barefoot doctors, emblematic of the post 1950's communist government, grew out a of a pre-WW2 Rockefeller initiative.[586] Still, emphasis remained on education, and human capital building as the key resource for development. As World War 2 dismantled colonial empires across the globe and gave way to the politics of the Cold War, the Rockefeller foundation, among other American foundations, yet again reassessed their strategies. By 1951, the Rockefeller foundation chose to discontinue its public health arm, the International Health Board. As the physicians of the division came to realize, their socially abstracted, disease-focused approach was limited, and "the slashing attacks on epidemic diseases, at first so rapidly successful had disclosed social

585 Ma, "The Peking Union Medical College and the Rockefeller Foundation's Medical Programs in China," 167.

586 Bullock, *The Oil Prince's Legacy.*

and economic roots which retarded their suppression and could no longer be ignored."[587] Fred Soper, head of the international health division, felt that new international organizations such as the WHO, founded in 1948 and intergovernmental cooperative programs such as the Pan-American Sanitary Bureau could better handle the scale of interventions public health truly needed.[588] In addition to the WHO, other trans-national organizations such as the IMF and the World Bank took on development work previously led by American philanthropy. In the changing context of the Cold War, the foundation chose to continue to support medical education, and add a renewed emphasis on the social sciences, "in order to make democracy function…to the end that a disorganized world may not chose the alternative of Communism."[589]

Thus, conventional histories such as Farley's attribute the relative demise in prominence of the American foundations to the emergence of international organizations as well as direct development efforts by the US government after the end of WW2. Other perspectives, however, demonstrate a more complex reality. Previous foundation policies and philosophies of development became the models for governments and organizations like the WHO and the IMF to follow. Furthermore, individual experts and policy makers who established foundation policies were often connected to or in some cases the very same people who developed government and international organization policies. As Berman argues:

> …the architects of post WW2 foreign policy enjoyed close relationships to the major foundations and large corporations …indeed many of these individuals regularly moved back and forth between corporate headquarters, foundation offices, and State or defense department positions. An understanding of what

587 Farley, *To Cast Out Disease*, 277.
588 Farley, *To Cast Out Disease*, 273.
589 Quoted in Farley, *To Cast Out Disease*, 278.

> lead them to formulate certain polices in one position helps to account for their decisions while occupying another[590]

This "revolving door between Wall Street and Cambridge, Massachusetts, to the corridors of Washington D.C." accounted for the continuity between previous foundation-lead development strategies and the policies of the US government and transnational organizations. As Parmar argues, through this process, the major philanthropic foundations became influential "silent partners" in American foreign policy.[591] Parmar uses Antonio Gramsci's concept of "state spirit" to explain this relationship. Foundation leaders and their wealthy industrialist supporters consciously engaged in projects of nation-building through their work and were inspired to "take personally the concerns of the nation and state to subordinate narrow economic and political interests to the broader, long term interests of the state/nation as a whole."[592] Thus, when these individuals moved from the private sphere to public service, their goals and views did not change significantly. Since the 1950s at least three Rockefeller foundation presidents have held terms as US Secretary of State, including John Foster Dulles, Dean Rusk, and Cyrus Vance.[593] John J. McCloy, Rockefeller foundation trustee and chairman of the Rockefeller owned Chase-Manhattan bank became the first head of the World Bank in 1944. Trustees of the Ford Foundation, established in 1936 and focused on global higher education, also played prominent public service roles with Paul Hoffman becoming director of the Marshall plan and Robert S. McNamara becoming secretary of defense in the Kennedy and Johnson administrations and also head of the

590 Berman, *The Influence of the Carnegie, Ford, and Rockefeller Foundations*, 5.
591 Parmar, *Foundations of the American Century*.
592 Ibid, 23.
593 Berman, *The Influence of the Carnegie, Ford and Rockefeller Foundations*, 63.

World Bank.[594] Although ostensibly representing international voices through the UN, the World Bank and IMF have been heavily American institutions. Both organizations were conceived by the War-Peace Studies project, a Rockefeller-funded think tank of academics and policy leaders convened to develop post-war foreign policy strategy for the US.[595] Created at the Bretton Woods conference of 1944, the World Bank has always had an American president, with the US controlling over ¼ of the overall voting rights. This lineage of the "Bretton Woods," organizations, would determine their philosophies of development and their global impact for decades to come.

After World War II, although American philanthropic foundations seemed to have taken a back seat to US state department and international agencies in development efforts, their strategies and values became increasingly influential through the voices of their trustees, now heading these new leading entities. Thus the heavy emphasis of Cold War development work on higher education is unsurprising. In keeping with the US policy of "containment" of Soviet influence, development policies began by reconstructing war-ravaged European countries, and then turned their attention in earnest to the "hearts and minds" of the developing world. Their policies were undergirded by a "the conventional wisdom of the day," the belief that international investment and capitalist development were the best ways to achieve an "orderliness of economic growth," that would benefit developing nations and "engage directly the self-interest of the economically more advanced peoples and calls for their understanding and assistance."[596] Part of achieving this goal, however, was winning over the leaders of developing nations. Once again, the common sense of the day, and prior foundation

[594] Ibid, 63.

[595] Berman, *The Influence of the Carnegie, Ford and Rockefeller Foundations,* 43.

[596] Dean Rusk, quoted in Berman, *The Influence of the Carnegie, Ford and Rockefeller Foundations*, 65.

experience pointed to education as the logical starting point. Throughout the Cold War, foundations, often with the cooperation of the US state Department and international bodies implemented several strategies including fellowship programs to allow third world talent to pursue training in selected US universities, with the hopes that they would bring home both the technical skills and values of American culture. [597] The other arm of the strategy consisted of "developing a few first class universities in the non-Western areas…to be the principal training grounds for the individuals who provide leadership in government, business, industry, education the professions, and humanities."[598] This became the basis for the Rockefeller foundation University development program, initiated in 1960, which focused on flagship institutions in strategic areas. This later push was not as precisely focused on medicine and science as pre-WW2 efforts, yet the basic philosophy of "educate from the top" was still very much visible. In the context of the Cold War, however, this educational mission took on a new urgency, "preempting the most promising talent and projects" in these developing countries from the Soviets.[599]

INTERNATIONAL EXCHANGE PROGRAMS: COLD WAR GOALS AND UNINTENDED CONSEQUENCES

These structures and logics also animated State Department forays into educational development. Thus, beginning in the 1960s, various educational exchange programs were instituted both to bring foreign students to the US and to send Americans abroad. Although the Rockefeller foundation had been distributing fellowships to allow citizens of developing nations to study in the US since the beginning of the 20th century, these exchange programs began to interest the state department in earnest during the Cold

[597] Berman, *The Influence of the Carnegie, Ford and Rockefeller Foundations*, 67.
[598] Quoted in Berman, *The Influence of the Carnegie, Ford and Rockefeller Foundations*, 71.
[599] Berman, *The Influence of the Carnegie, Ford and Rockefeller Foundations*, 75.

War. A series of congressional legislation beginning with the efforts of William Fullbright in 1946 and culminating with the Fullbright-Hays act of 1961, stressed "mutual understanding between the people of the United States and other countries," by fostering bi-directional educational exchanges with a growing list of nations. [600] Widely successful, this program came to include scholars in the humanities as well as in technical fields. Scholars have interpreted this program and related educational exchanges as a quintessential expression of American "soft power" or, as Smith summarizes it, the use of cultural influences such as film, art, and education "to influence the hearts and minds of various foreign citizens" for the perceived strategic purposes of the United States.[601] Foundation leaders had long argued for education as an underappreciated arm of foreign policy. While foundations had acted as "silent partners" to US state interests for several decades, their strategies and the logics behind them were now widely adopted.

The Fulbright program was the flagship for a series of exchange arrangements. The J-1, or "exchange visitor" visa process, partly still in place today, became the primary path for health care workers such as doctors and nurses to seek training in the United States. As Catherine Ceniza Choy, exploring the effect of this program on Filipino nurse migration contends, though a seemingly defined "international exchange," in practice the program was embedded with "numerous complexities, mythologies and contradictions."[602] Choy argues, at least in health care, these visa programs often had unexpected consequences as they interacted in complex ways with legacies of colonialism, economic conditions, ideologies and global hierarchies. Although

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[600] The Mutual Educational and Cultural Exchange Act of 1961. Public Law 87-256 (September 21,1961).

[601] Smith, William S. "Send in the...Scholars?: The History of the Fulbright Program from 1961-1970." Bowling Green State University, 2011. Master's Thesis., 7.

[602] Choy, *Empire of Care*, 63.

circumstances varied by institution, in many cases both American employers and exchange nurses viewed this program through the lens of their own purposes. For many employers this new group of eager, well trained nurses became an affordable labor source at a time of increasing nursing shortages in the US.[603] The intention of the program was typical of Cold War era educational exchanges, to transform the visiting nurse into an "ambassador…who on her return home will mingle both with the average and influential people of her country," and "…will tell them about the way of life in the United States."[604] In reality, however, experiences varied greatly, and many nurses discovered that their time in the US was geared more toward service than education.

However, the exchange nurses also saw these jobs as opportunities for personal freedom and professional advancement not available in the Philippines. As heavy as their patient burdens were, working conditions were often less oppressive than back home, and nurses enjoyed much higher pay even with their relatively meager stipends. 10 years into the program 80% of participants were from the Philippines. Already educated in an American medical system, established in the colonial era, these nurses had skills almost immediately transferable to American hospitals. In recalling a history of elite Filipino nurses and medical trainees who had traveled abroad a generation earlier on Rockefeller fellowships, bringing back ostensibly superior knowledge and skills and experiencing social and professional mobility as a result, the exchange program, Choy argues, "recreated the racialized social, cultural, and intellectual hierarchies of US colonialism in which US institutions- medical, political, educational were superior to those in the

603 Choy, *Empire of Care*, 78.
604 Ibid, 66.

Philippines."[605] These racialized assumptions became embedded in the professional culture of Filipino nurses and doctors.

In this context, assumptions by American policy planners and nursing leaders that Fillipino nurses would fulfill their two year contracts and bring back their American skills and cultural goodwill proved naïve. Many nurses who returned found their new skill sets were of limited utility in the more resource-limited environment of the Philippines. Furthermore they were not able to achieve the career mobility they had hoped for. Their international experience prepared them better to work in the US than to somehow reform the Filipino medical system. As one returnee wrote, her experiences abroad taught her "how backward we are."[606] Another returnee was more descriptive in her comparison, "the thing I love about American hospitals," she told Choy, "we have enough supplies and equipment…In the Philippines we boiled our own rectal tubes. You use catheters over and over…here you use it once and dump it out."[607] Many of these exchange nurses did their best not to leave the US, or returned home only to seek out permanent positions in the US when their visa-mandated 2 year waiting period was up.

These exchange programs, initiated by the foundations and scaled up by the national initiatives they inspired, began to have increasingly apparent unintended consequences, especially in health care. Choy's case study of Filipino nurses was recapitulated among other groups of nurses and doctors as well as technically skilled groups such as engineers.[608] The combined legacies of colonialism and in some palaces,

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[605] Ibid.

[606] Ibid, 67.

[607] Ibid, 86.

[608] Studies in engineering education, development, and globalization provide some interesting parallels with the situation in medical education. Stuart Leslie and Robert Kargon, for example, describe the attempt in the 1960s and 70s to establish "junior MIT's" in Indian and Iran. Inspired by the success of MIT in the 1950s, American as well

quasi-colonial foundation involvement, instilled a common-sense notion of Western knowledge and systems as evidently superior and related attitudes that bestowed prestige to emigrating. Likewise, state of the art, Western-oriented training models established by American foundations and colonial governments, as in the Thai example in the last chapter, resulted in young physicians, nurses, and other technical professionals with a skill set and clinical orientation that was abstracted from local needs. Rockefeller foundation emphasis on building "the Johns Hopkins of…" was well intentioned, and successful in producing world class clinicians, albeit with narrow biomedical foci in their approaches to health and illness. Those clinicians, however, were not adapted to work in poor environments where the structural determinants of health were much more pronounced. When simply educating physicians proved inadequate for improving the health systems they worked in, migration was frequently the result. This became more and more apparent as the demand for skilled health workers grew in developed nations such as the United States, the United Kingdom, and Canada. Just as UK recruitment jumped with the establishment of the NHS, American need for health workers grew immensely with the institution of Medicare and Medicaid in 1965, coincidentally the same year as major immigration reforms. These reforms shifted US immigration policy from a nation-of-origin quota system to one the emphasized professional skills and family reunification.[609] The confluence of these two reforms had some dramatic effects on the

Indian and Iranian engineers sought to reproduce the MIT formula in these developing countries, with the hope of fostering development. Although results were mixed, in general outcomes were parallel to those in medicine—producing world class professionals that were unlikely to find a way to employ their skills. Leslie and Kargon quote an Indian witticism, , "when a student enrolls at an IIT, his spirit is said to ascend to America. After graduation, his body follows."

609 Ong, Aihwa. *Flexible Citizenship: The Cultural Logics of Transnationality* (Durham, NC: Duke University Press Books, 1999). 129-130.

composition of US health care workforce and the national debate about international physicians and nurses (as discussed in chapter 3.)

This combination of negative perceptions of the local work environment, coupled with the prestige and material benefits of working abroad, whether transiently of permanently, contributed to what Choy and Connell call "a culture of migration." Choy documents the emergence of this culture among nurses and physicians in the Philippines. As she defines it, migration becomes ingrained in health worker identities, and the prospect of migration becomes a factor in deciding to pursue a career in health care.[610] Connell applies Choy's perspective more broadly: as the quality of training increases for health workers "limited local resources and demand frustrate attempts to use new skills."[611] Migration becomes the outlet through which workers can feel that they are doing work appropriate to their professional standards. Likewise the assumption that "training outside [the] home country is superior and a mark of achievement" is fueled by the sometimes apparent material deprivation of local areas, and also by unstated colonial and racialized legacies.[612] Connell also locates the medical culture of migration as interlaced with "an existing, more pervasive culture of migration."[613] He employs anthropologist George Marcus's concept of transnational corporations of kin to explain family and larger cultural pressures that encourage learners to enter the health care field for its prospects of migration. The ability of these workers to migrate benefits entire family networks as they send home remittances and bring local prestige as well as additional migration opportunities to other family members. As demonstrated previously

610 Choy, *Empire of Care*, 4.
611 Connell, *Migration and the Globalization of Health Care*, 89.
612 Aly and Taj 2008 quoted in Connell, *Migration and the Globalization of Health Care*, 89.
613 Connell, *Migration and the Globalization of Health Care*, 92.

,"brain drain" was structurally interlaced with cultural norms of higher education, particularly in medicine.[614] It was also, however, embedded in larger cultural legacies.

The incommensurability of skills with local needs and resources, as evidenced by Choy's example, is a frequently cited contributing factor to migration. As we shall see in subsequent chapters, this was a theme that appeared frequently in my interviews with IMGs. In many ways this phenomenon is an unintended and paradoxical consequence of a development philosophy that has held sway for generations. As Parmar argues, "even the US foundations' own assessment of their impacts show that they largely have failed," in efforts at "eradicating poverty, uplifting the poor, improving living standards, aiding economic development," and making significant strides in human health and health systems.[615] However, the ideology of development through support of higher education has a remarkable staying power, even in the face of evidence that although it succeeds in producing capable scholars and leaders across fields, it does not equip them to change the fundamental structures in which they function. These are skills and insights critical scholars such as Brown, Parmar, and Berman argue were fundamentally outside of the scope of vision of foundation trustees and officials, ideologically and pragmatically focused on technical solutions. A later Rockefeller foundation report criticized the third world universities they themselves built as "dysfunctional and disoriented,' which was attributable to their adoption of American and other Western university structures 'with little thought or effort given to the questions of how this mode of academic organization would fit or serve existing conditions." Yet, this strategy, perhaps unwittingly continues

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[614] According to David Wright et al, "brain drain" as a term emerged in the 1960s, right as these trends were becoming apparent. Interestingly, as first applied in health care, "brain drain" referred to the loss of physicians from the UK to Canada and US—mainly in response to limited advancement opportunities in the NHS system. Wright et al. 2008.

[615] Parmar, *Foundations of the American Century,* 11.

to define many elements of development work, with another report suggesting "strategies for meeting the problem of the Brain Drain" that involved the further building and support of university networks.[616]

NEOLIBRERALISM AND THE LATEST WAVE OF PHYSICIAN MIGRATION

The words of Nigel Crisp, global health scholar and former head of the NHS summarize some of the arguments I have made in the preceding two chapters. He describes the migration of physicians and other healthcare workers as "one half of an unfair import-export business in which poorer countries export, mostly unintentionally and unwillingly, many of their health workers whilst at the same time receiving the, often inappropriate and sometimes discredited ideas and ideologies of richer countries."[617] Among these discredited ideas were the development strategies based on the ideologies that animated reforms in US healthcare discussed above, including the great foundations "educate from the top" approaches to medical and technical education as well importing narrowly clinical and technical models of health and care to resource-poor settings. Beginning in the late 1970s, however, another powerful ideology, which scholars have come to call neoliberalism began to hold sway in development circles. As many social scientists have documented, the consequences, intended or not, of neoliberal thinking on development broadly, and particularly in healthcare have in some cases been not just inappropriate, but devastating. These effects have in turn acted in increasingly perverse ways to rapidly increase physician migration from poor to rich nations.

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616 Parmar, *Foundations of the American Century*, 11.

617 Nigel Crisp, *Turning the World Upside Down: The Search for Global Health in the 21st Century* (London, UK: CRC Press, 2010), 65.

Briefly, neoliberalism originated among a small group of mostly American and British economists as a reaction to the hegemony of Keynesian economics adopted by leading governments from the 1930s until the 1970s. Exemplified by the American New Deal, Keynesian principles, advocating activist economic policies by governments during hard economic times were gaining traction throughout Europe after the Great Depression. As the title of a book by one of the group's leaders, Fredrich Hayek's *Road to Serfdom* suggests, this group felt strongly that central planning and central government involvement in the economy endangered not only economic, but political freedom. [618] Instead this group saw value in the ideas of Adam Smith and his conception that "the hidden hand of the market was the best device for mobilizing even the basest of human instincts…for the benefit of all."[619] This engendered a belief that state interference in the operation of the market was inherently problematic, either because it was inevitably biased by the influence of interest groups, or most importantly, because "the information available to the state could not rival that contained in market signals."[620] The state, as they initially envisioned it, was to fulfill a strictly defined, limited role, offering strong protections to private property, enforcing contracts, maintaining the rule of law, and protecting freedom of action, expression, and choice.[621] Despite claiming bastions at the London School of Economics and the University of Chicago for much of the post-war period, the neoliberals found themselves to be very much an outside voice in a postwar framework of "embedded liberalism," formulated both by individual states and by a "new world order" embodied in the Bretton Woods agreement (discussed above). The intent

618 Phillip B. Smith and Manfred Max-Neef. *Economics Unmasked: From Power and Greed to Compassion and the Common Good* (Devon, UK: UIT Cambridge Ltd., 2011),33.

619 David Harvey, *A Brief History of Neoliberalism* (New York, NY: Oxford University Press, 2007), 20.

620 Ibid, 21.

621 Ibid, 61.

was to "construct the right blend of state, market, and democratic institutions to guarantee peace, inclusion, wellbeing and stability."[622]

Only when this framework began to crack in the late 1960s and early 1970s did the neoliberal contingent get the opportunity to turn theory into practice. Though often presented as a "utopian project" to reorganize global capitalism, it can also be viewed as a "political project" to sustain the power of the ruling elites.[623] Neoliberal policies globally have been legitimated with "rhetoric about individual freedom, liberty, personal responsibility, and the virtues of privatization," yet as many scholars claim, their consequences have in fact promoted inequality, legitimated draconian policies, and increased market dysfunction.[624] Since the critical period in the late 1970's to the early 1980's, argue Harvey, and Smith and Max-Neef, neoliberalism has been the dominant economic ideology, defining trends in the distribution of wealth, conduct of business, and the relationship between rich and poor countries. During this era, neoliberalism rapidly became the ruling "common sense" of the global elites that fostered development work as heads of corporations, foundations, governments, and transnational agencies. Instituted in the IMF and the World Bank, neoliberal policies were applied to poor nations as self-evident paths to development even as they engendered controversy in the rich nations that imposed them. In their roles as primary lenders to the governments of the developing world, these institutions have been in positions of power to set the terms of those loans—often this has included imposing "structural adjustment programs," intended to encourage

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[622] Ibid. 10.
[623] Ibid. 19.
[624] David Harvey, *The Enigma of Capital*. (Oxford, UK: Oxford University Press, 2010), 10.

developing nations to become more fiscally responsible.[625] These structural adjustment programs have required economic austerity, demanding debtor nations cut their already weak infrastructures of social provision, among them, healthcare systems.

As Armada and Muntaner argue, these policies have been touted as essential for economic growth in "stabilizing national economies, controlling inflation…opening national economies to international trade, increasing the flexibility of labor markets and reducing government intervention."[626] Rather than ensure the good of the citizens of low and middle income countries, however, these policies instead "reflect IFI's (International Financial Institutions') goals to ensure that medium and low income countries pay their external debts."[627] When implemented in the healthcare sector, Armada and Muntaner argue, policies of privatization and public divestment have not shown to improve outcomes, and evidence is mounting that they have been positively harmful to health.

As Connell argues, in terms of the roles of skilled healthcare workers, these policies, instituted in many struggling African, Latin American, and Asian countries, dealt serious blows to these nations on multiple levels. Many structural adjustment programs demanded "restrictions in the public sector workforce," resulting in hiring freezes for doctors and nurses. Thus newly graduated doctors and nurses, often the products of schools established for the benefit on their nations by earlier development schemes found themselves simply unable to find work. Connell cites the example of Mali in 1985, which could only employ 15% of its medical graduates, despite extensive need

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625 Kema Irogbe, *The Effects of Globalization in Latin America, Africa, and Asia: A Global South Perspective* (Lanham, MD: Lexington Books, 2014), 63.

626 Arachu Castro and Merrill Singer. *Unhealthy Health Policy: A Critical Anthropological Examination* (Walnut Creek, CA: Altamira Press, 2004).

627 Castro and Singer, *Unhealthy Health Policy*, 30.

for their services. In 2005, half of all nursing posts in Kenya were unfilled, even as one third of Kenyan nurses were unemployed. The work that was available in country, furthermore, was increasingly demoralizing. In Connell's words, "restructuring sometimes meant the deterioration of working conditions, rather than the greater efficiency it was intended to encourage."[628] Fewer doctors and nurses now had to marshal dwindling resources to provide care for more people. The timing of these restructuring programs, instituted in the 1980s and 90s was particularly harsh, occurring in African nations just as the HIV/AIDS pandemic placed enormous demands on the health sector. As Pfeiffer clarifies, the international aid that became available for health efforts in many of these countries has, as a matter of policy, been channeled through international non-governmental organizations, or NGOs, not these nations' public health sectors. Ironically, some of these efforts further exacerbated the overburdening of the public system, enticing local doctors and nurses away from clinical work with high salaries and better working conditions.[629] Under these circumstances migration to rich nations became the answer for increasing numbers of doctors and nurses educated in low and middle income countries. In Connell's analysis, the structural adjustment policies of the 1980s and 90s "stimulated the third and largest phase of international migration" for doctors and nurses.[630]

As Farley remarked in the concluding chapters of his history of Rockefeller foundation public health work, the beginnings of the mass migration of professionals, many of them educated at universities sponsored by the Rockefeller and Ford foundations

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628 Connell *Migration and the Globalization of Health Care,* 37

629 Pfeiffer, James. "International NGOs and the Mozambique Health Sector: The Velvet Glove of Privatization." In *Unhealthy Health Policy: A Critical Anthropological Examination*, ed. Arachu Castro and Merrill Singer (Walnut Creek, CA: Altamira Press, 2004.)

630 Connell, *Migration and the Globalization of Health Care*, 36.

as well as governmental aid contributions apparently contradicted their sponsors' expectations that they would function as agents of development in their home countries. In his interpretation, rather than a "trickle down" of the benefits of development to the impoverished, countries such as Brazil, India, Mexico, and Nigeria saw a trickle up to a new elite who were seen as guilty of not only exploitative behavior towards their own people, but who also had emigrated in large numbers to the wealthier countries of the world."[631] Beginning the 1970s, foundation officials began to reexamine their strategies, sharing Farley's disappointment in local elites. The role of foundation policies, and the shift to neoliberal strategies of development in constructing the conditions of this migration, however, went largely unacknowledged. Elite education, they concluded, was not an effective strategy for broad-based development. Yet even development strategies that took this knowledge into account sometimes encountered the same problems. As Claire Wendland argues in her ethnography of Malawian medical students in the 21st century, biomedical training in the global South is complex. In the next chapter I will draw on interviews with visiting and immigrant clinicians to discuss some of these complexities and explore some additional aspects of this story. As she elegantly demonstrates in her ethnography, her subjects did not narrowly consider self-interest when contemplating work and potential migration, but engaged in a complex negotiation, defining their identities as physicians and citizens "when their working lives are in every respect shaped by the same structural violence that produces patients' suffering."[632]

631 Farley, *To Cast Out Disease*, 288.

632 Claire L. Wendland, *A Heart for the Work: Journeys through an African Medical School* (Chicago, IL: University of Chicago Press, 2010), 24.

Chapter 7: Medicine's American Dream: The Good Doctor in a Globalizing World

In a 1997 article published in the *New Yorker*, Indian-trained internist Abraham Verghese recalls his state of mind when he chose to leave India at the end of his internship year to pursue a career in the United States. To him and his fellow young doctors,

> America was the land where there was no dichotomy between what the textbook said you should do and what you *could do*—or so we thought. In America your talent and hard work could take you to the very top. It was the land of defibrillators on every ward and disposable *everything*, by God. No more mucking around in the murky waters of a lukewarm sterilizer for a needle that could actually penetrate skin.[633]

In his fictional work, *Cutting for Stone*, Verghese puts these feelings in the mouth of an internist, himself having practiced a lifetime in an African mission hospital, advising his medical student son:

> …All of these years I've read *Harrison's* and the other textbooks…and the things they do, the tests they order…it's like reading fiction, you know? Money's no object. A menu without prices. But if you can get there, it won't be fiction. It'll be true.[634]

In this chapter I challenge the apparently self-evident notion put forth by policy makers, concerned physicians, economists and other commentators that money, status, and other external goods are the primary drivers of physician migration in a globalizing and unequal world. Although I do not discount the role of these factors, and explore the complicated ways in which they operate in other chapters, this chapter will explore how physicians' decisions to migrate are deeply entangled with their education and identities

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633 Abraham Vergehese. "The Cowpath to America." *The New Yorker.*

634 Abraham Verghese. *Cutting for Stone*, 433.

as doctors. Verghese, speaking as himself and as his fictional alter ego, expresses what I call the Dream of American Medicine. Like the notion of the broader American Dream itself, the Dream of American Medicine has complex cultural roots and often takes many forms. Echoed in different iterations among the physicians I interviewed, in ethnographies of medical training, in international physician narratives, and in historical sources, this dream envisions practice in America, and sometimes in other developed nations, as the antidote to struggles physicians often face in resource-limited settings. These struggles, ironically, often emerge out of the gulf between the technical and ethical lessons of these physicians' "world class" medical educations, and the realities of medical practice. In some articulations, emigration to a rich-world setting is seen as the only way to become a "real," or a "good" doctor, either by permanently moving to a situation where technologies and infrastructures of curative care are more available, or by a temporary stay to gain a skill set not available at home. Like the broader notion of the American dream, however, the American Medical Dream also has a dark side, a sometimes rude awakening when the migrant realizes that America, and American medicine isn't always what he or she had imagined it to be. In the following pages I will draw on theoretical work in the medical humanities and medical anthropology, ideas from the preceding historical chapters, and finally, interviews I conducted with IMGs to articulate the origins, effects, and permutations of the American Medical Dream.

MEDICAL EDUCATION, PHYSICIAN IDENTITY, AND THE MORAL CORE OF SCIENTIFIC MEDICINE

Classic work in medical humanities, medical sociology, and philosophy of medicine has sought to define the role of medical education in identity formation, character development, and ethical orientations of medical students. Much of this work, briefly reviewed here, has mostly focused on American medical students as archetypal medical learners. Particularly older studies, as evidenced by the title of Becker, Greer, Hughes, and Strauss's 1961 classic, *Boys in White*, envisioned these individuals as mostly Anglo, male, middle and upper class Americans. Kathryn Montgomery, whose "extended essay" on medical learning I will draw on later, very deliberately explains that her observations are also located in the context of American medical plenty, "in tertiary care medical centers," with "the full panoply of Western medicine," where students are "the best and brightest, standards are the highest," and "peer review at its sharpest."[635] Work in medical anthropology has slowly begun to expand these studies into the cultural contexts of less affluent nations—testing whether their formulations stand up to alternative realities of medical learning and practice, and complicating some long held assumptions.

Bioethicist, physician and philosopher Edmund Pellegrino, arguing for existence of an internal morality of medicine, defines medicine as a practice in an Aristotelian sense, and in the process, provides a useful basis for classifying *goods*, or *excellences* that I will use as reference points in this discussion. Pellegrino argues that "there is something essentially in the nature of medicine as a kind of human activity which determines its

635 Kathryn Montgomery, *How Doctors Think: Clinical Judgment and the Practice of Medicine*. New York, NY: Oxford University Press 2006) 10.

ends and its ethics internally."[636] This ethic is based on the medical encounter, where a patient comes to a doctor asking for help, thus "the good of the patient becomes the telos of medical activity."[637] Thus, medicine, he argues, at its core and regardless of context, is a practice, defined by that ethic. He draws on Alistair MacIntyre's classic work, *After Virtue*, to define just what that means. To MacIntyre a practice is "any coherent and complex form of socially established cooperative human activity through which goods internal to that form of activity are realized in the course of trying to achieve those standards of excellence which are appropriate to and partially definitive of that from of activity."[638] Medicine, like any practice, then has *internal* and *external* goods. Goods external to practice, such as "prestige, status, and money," can be achieved multiple ways, but goods internal to practice, can only be achieved through the practice itself.

In becoming adherents of the practice of medicine, medical learners, perhaps however imperfectly, adopt its notions of the good as excellences that define them as practitioners. They "function within a community with defined standards, skills and virtues, which are not individually determined by practitioners."[639] For Pellegrino, for example, "Excellence in healing is, then, a good internal to that practice; making money is a good external to that practice."[640] Working for the "primary defining good" of medicine, "to make a right and good decision for *this patient*," defines what makes someone a "good physician."[641]

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[636] Edmund D. Pellegrino. "The Internal Morality of Clinical Medicine: A Paradigm for the Ethics of the Helping and Healing Professions." *The Journal of Medicine and Philosophy* 26, no. 6 (December 2001): 559–79.

[637] Pellegrino, "Internal Morality," 561.

[638] Alasdair MacIntyre, *After Virtue: A Study in Moral Theory, Third Edition*. 3rd ed. (Notre Dame, IN: University of Notre Dame Press, 2007) 187.

[639] Pellegrino, "Internal Morality,' 563.

[640] Pellegrino, "Internal Morality," 562.

[641] Pellegrino, "Internal Morality," 564, 568.

Kathryn Montgomery also argues that medicine is characterized by an innate value system founded on the "Levinasian moment," of the clinical encounter where "a physician becomes a physician only by taking care of patients."[642] In her study of medical epistemology, she argues that medical education indirectly imparts these values under the guise of technical and scientific training. The "moral is buried in the clinical," she argues, and this moral formation of medical learners is "experiential, behavioral, and in important ways, covert."[643] Medical education claims to shape physicians into scientists, in an old-fashioned, positivist, Newtonian sense. Thus the pre-clinical years of aspiring medical students in the American medical schools she has worked in are packed to the brim with technical minutia, leading to the expectation that "physicians' knowledge is "invariant, objective, and always replicable."[644] For these medical students, the transition to clinical training can be jarring. Rather than applying science, they find that medicine is about coping with uncertainty in high stakes situations. When confronted with this "irony of medicine" many describe this contrast as personally distressing. "Medicine," they discover, though perhaps they do not always articulate, "is not a science; physicians must act. They must do the best they can, even when they don't know all there is to know, even when there is nothing to do." What medical students eventually learn, she argues, is not science, but clinical judgement, akin to Aristotle's *Phronesis*, a learned, holistic rationality for applying information, and managing contingency with the moral aim of doing the best for each individual patient.

Montgomery, like Pellegrino, presents the doctor-patient relationship as the ethical core of medicine. This valorization of this ethical center comes under critique

642 Montgomery, *How Doctors Think*, 161.
643 Ibid, 4, 160.
644 Ibid, 16.

from critical social scientists, who suggest it is this very client-centeredness, shared with lawyers and other members of the traditional professions that blinds medicine and its practitioners to the social context of their work and their patients' distress.[645] Montgomery too, is aware of this glaring flaw of modern medicine, but traces it not to the core ethics of medicine, but to a phenomenon with its own particular history--the consequences of medicine's continued "mis-description" as a science, a product of the last two centuries. One that she asserts has "led to a harsh, often brutal education, unnecessarily impersonal clinical practice, dissatisfied patients, and disheartened physicians." Medicine, she argues, exemplified its values of attention to detail, skepticism, and commitment to patients way before it took on the cloak of science. The charade of medicine as a science, she argues, limits clinicians' concept of what they are empowered to do for the good of the patient, in essence presenting them with a dichotomy between technocratic versus social solutions.

Medical Education in Resource-poor environments: Unexpected Lessons

Claire Wendland, physician-turned anthropologist examines how these formulations of medical learning and values function outside of the rich-world context. In her ethnography, *A Heart for the Work*: *Journey's Through an African Medical School,* she describes the experiences of medical students, interns, and young doctors in a recently-founded medical school in Malawi and its affiliated tertiary care hospital. She asks, "where access to the machinery of techno-science is extremely limited, do medical students still create a moral drama in which techno-science is the savior of the afflicted?

[645] Michael S. Goldstein and Peter J. Donaldson. "Exporting Professionalism: A Case Study of Medical Education." *Journal of Health and Social Behavior* 20, no. 4 (December 1, 1979): 322–37.

Do doctors-to-be still identify as elite white males in a world where the elite white male was historically the colonial agent or the missionary?"[646] What she discovers, is that when it comes to the subliminal moral lessons of medical education, and the identity formation of young doctors, context matters, and the same scientific curriculum can be a vehicle for very different lessons. Like the medical learners Montgomery observed in the high technology environments of American medicine, Malawian medical students also receive a world class biomedical education, heavy in the basic sciences. Wendland observes, "nearly all the textbooks the College of Medicine used came from first world settings and were oriented toward first world techno-medicine; many were the same classics …over which I had poured in medical school in Michigan."[647] First year medical students in Malawi, like their American counterparts, saw a future where they used their scientific knowledge and skills to cure the sick.

For Malawian students, however, the clinical years, spent in the heavily overburdened, under- resourced hospitals of a poor country, were all that much more of a shock. While their first world counterparts had to square their scientific education with the innate uncertainty and contingency of applying abstract science to particular patients, these students had to face up to the often demoralizing reality that even when they knew what to do for patients, they simply lacked the resources to do it. Seeing 60-100 patients a day, lacking basic amenities such as antibiotics, gloves, and even beds, the medicine these students experienced was incommensurable with the medicine depicted in their textbooks. Each experience, from admitting patients with diseases of poverty, to describing a patient's avoidable death for lack of a cheap drug at handover rounds,

646 Wendland, *A Heart for the Work*, 130.
647 Wendland, *A Heart for the Work*, 130.

"nearly always featured tensions between what doctors thought should have been possible, and what actually happened." Her subjects "often commented on the disjuncture between textbook and clinic." They "learned about diseases of the elderly but had no elderly patients. They learned about neuroimaging and fluoroscopy and care of the extremely premature neonate, but had access to none of the equipment necessary."[648] In Verghese's words, they realized that they might as well have been "reading fiction."

The result, according to Wendland, was often a period of deep disillusionment. "Faced with their own powerlessness in the face of medical need and system-wide breakdown," the students often expressed anger over government neglect, corruption, and the overall poverty of their nation.[649] In response, many of Wendland's subjects "actively forged" identities and ethics as physicians. The "practical ethics" of these negotiations leads Wendland to theorize that rather than an a "moral order" built in to medicine, her students experienced the ethical lessons of medical education as a "moral economy," adapting cultural materials at hand to create their own definitions of what it is to be a "good" doctor. Her interviewees, it seems, took two broad paths, each its own articulation of how best to enact a medical ethic centered on the care of the individual patient. Many expressed that in a setting of "clinical poverty" and "intractable patient problems," a good doctor had to develop "a heart for the work," or a "heart for patients."[650] In the absence of technical capability, they chose to value qualities of empathy, advocacy, resourcefulness and teamwork as the best way to care for patients. Another group, however, remained disillusioned, feeling that "real medicine was what happened elsewhere." At least a third of her informants felt they would at some point leave Malawi. One of her informants told

[648] Ibid, 131.
[649] Ibid, 39.
[650] Ibid 177, 179.

her: "there are no nurses. There is no equipment. There are no syringes. You come to work, you leave patients suffering because there is nothing you can use to help them… I don't want to end up here, I want to be someone else in the world."[651] For this individual at least, his identity as a Malawian became increasingly incompatible with his identity as a doctor. Immigration was a path to achieving his conception of himself in medicine, as a doctor who does not have to leave patients suffering. Thus taken together, Wendland, Montgomery, and Pellegrino all locate medicine's ethical center around the doctor's responsibility to each patient. As Montgomery explores, however, as powerful as this ethic is, it is often subsumed by an additional, historically bound ethos of medicine as a scientific endeavor and technological enterprise. In first world environments, the conflict between these ethics creates particular forms of distress and coping in medical students. Students learn to hold themselves to high standards of performance while to some degree accepting that doing the best for individuals can be an uncertain enterprise. As Wendland describes, in at least one resource-limited environment, the balance between these two elements can result in very different moral lessons, even among one class of medical students. Tacitly accepting the idea that a doctor is not a doctor without patients, many cope with the question: is a doctor a doctor without the ability to *do something* for patients? And more fundamentally, what does *doing something* mean? Is a doctor a doctor when she cannot offer the promise of scientific medicine and technology to patients?

One of the most striking elements of Wendland's work is the contrast between the world class medical education Malawian medical students receive, the resources they

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[651] Ibid, 188.

actually have to work with as physicians, and the medical conditions they are called upon to treat. As discussed in earlier chapters, this bizarre, even surreal situation has particular historical roots, anchored in a legacy of both colonial medicine and in a century of public and private "development" work. This historical work also demonstrates that although the consequences of this mismatch are deeply poignant in Malawi, it is by far not the only setting facing these ironies. Development work aimed at improving medical systems in poor nations has consistently focused on medical education as a primary locus of intervention. The actual healthcare systems, and the broader social and political contexts in which these physicians would be working, however, were often given much less attention. As in the case of Rockefeller Foundation work in Thailand and China in the first half of the 20th century, locally educated physicians soon became painfully aware of the mismatch between their training and their ability to effect change, or even function in their environments. Faced with increased possibilities for migration created by the demand of countries whose resources permit physicians to actually use the training the received, many have chosen to leave. As Wendland observes, "in justifications for promoting biomedicine abroad…it is very difficult to disentangle the desire to address tremendous suffering, the desire to open new markets for pharmaceutical products, tests and devices, and the desire to use health care as the effective arm of foreign policy…" These efforts often provide valuable resources for needy places, yet often have unintended consequences, among them the situations they create for poor nation's medical trainees.

FAMINE AND PLENTY: RESOURCES AND PRACTICING "BY THE BOOK"

In interviews with physicians who migrated to the United States from middle and low income countries, contrasts in the availability of resources often figured prominently. These discrepancies were often brought up for various reasons, and the physicians I spoke to coped with them differently. In many cases, the challenges of medical practice at home, or the promise of medical practice abroad were a large part of the calculus for leaving home either temporarily or permanently. Some physicians described the circumstances that they practiced under as trainees and early career physicians in their home countries as extremely difficult or impossible. A repeated locus of frustration was the inability to do what they felt was right by patients, sometimes at a very basic level. The physicians I interviewed responded to these pressures in various ways. For some, migration was a way of achieving the dream of doing what you needed to do for patients, to be able to practice, in the words of one interviewee, "by the book." For others, migration had specific goals, to gain knowledge or skills to help respond to these pressures, hoping to return home more prepared in some way to help patients either medically or on a broader social scale.

The ways that these physicians expressed professional motivations for migrating were deeply entangled with their understandings of what it means to be a doctor. A minority, for example, foregrounded the scientific and technocratic aspects of medicine: emphasizing opportunities to do research, and to access the most advanced technologies. Many, however, emphasized an ethic based on the doctor-patient relationship, describing distress at not being able to help patients in the ways their education had prepared them to do. To varying degrees, some physicians also articulated a balance between wanting to

move someplace where they could care appropriately for individual patients, while feeling an obligation to the patients in need in their home societies. Few interviewees come to the United States with the certain intention to become permanent immigrants. For some immigration was a possibility, but so was return. Several describe embarking on their journeys to the US with a clear intention to achieve a goal and return home. Once again, the gulf between resources in the US and at home proved challenging and often changed these plans.

Several interviewees foregrounded the challenges of working with limited resources in their countries of origin. Laila A., a physician from Pakistan, remembered her experiences working in obstetrics in a displaced persons camp in years before she came to the US:

> … its extremely frustrating and my God there was a point where I felt that I was banging my head against a wall every day just to get the most basic things done…you know working in resource-poor environment has its challenges… so in those places one day you have all these gloves and everything's great and a week after that you're doing a delivery and you ask for gloves and they're like "oh, we're out." And then you deliver and they're like "the electricity's gone off, and the backup generator's on but it wasn't connected to the water supply so there's no water." So between deliveries I actually had to wash my hands with a patient's Pitocin drip, like just to get the overt bloodstains off…And then just the corruption, like the hospital administrator wouldn't release scissors. You would use the same scissors to cut the cord, to do an episiotomy. And then you go and try and find out what's going on and you start asking questions and that becomes an issue, because "why are you asking questions about where the scissors are?"[652]

For some of these physicians, the stresses of limited resources were coupled with high-pressure training environments. Another physician, Esther L., who trained as an Internist in Uganda and Kenya remarked that above all other resources, her time for patients was

[652] Laila A. interview with author, November 2014. All interviewees were anonymous, they are identified here with pseudonyms selected by the author for clarity.

perhaps the most scarce of all as she also observed how some of her attendings handled the pressure:

> I think number one I would have to say from my own experience in medical school… even when I finished, when I was working myself … is … the volume of patients….So the wards would be filled to capacity, people on the floor, people on the beds. So you really don't have that much time get into all the details about one particular patient because you have 60 others sitting ... So…the volume was sometimes overwhelming for this one person who was also teaching and mentoring students and residents and what not … a lot of the physicians there, because you know those jobs in the academic centers don't pay as well, a lot of them have private clinics so … they have to finish what they are doing and rush off to their clinic…the volume of the patients just to be honest doesn't allow that level of attention.[653]

For these two physicians, both training in the 2000s, though in different national and political contexts, the common theme of resource limitations was in and of itself a cause of distress, making them constantly aware that they are not providing patients with what they deeply felt was an appropriate level of care. Several of my interviewees described the irony of their educations—which would be considered high quality by any global standard. This background, they comment, provides a standard by which to judge their work as clinicians. Rather than prepare them to function and much less to improve the resource-limited situations in which they end up training and practicing, however these backgrounds and skills give them little guidance, and often serve to highlight the limitations of their surroundings. Comments emphasizing quality of education were common. A Salvadorian-educated gynecologist, for example described her medical school experience as on par with anything available globally: "I went to an excellent private medical school…like we had a lot of simulation. I found that when I came here (to UTMB) there were not really simulation labs for the students and said when I was a

[653] Esther L. interview with author, January 2015.

medical student I was already having simulation labs back home… You operate since you are in your clerkships. I mean you have very good clinical training"[654] Laila A. described her medical school, a private, foundation-funded university in Karachi as "very state of the art…very competitive," affiliated with a JACHO accredited-hospital and maintaining long-term partnerships with Harvard and Indiana University, among other Western institutions. Like all competitive medical schools in Pakistan, instruction was in English. For students, taking the US NBME step exams was a powerful social expectation, as she put it: "when I took my steps…If anybody got a 98 instead of a 99 people would come up to you and sort of commiserate, "oh my God, we're so sorry, you got a 98 you didn't get a 99," it's just that kind of place."[655] In retrospect, she describes her experience at Aga Khan University as "almost like being in a bubble. We did get exposed obviously to healthcare in Pakistan but because it was this hospital it was easier when transitioning into the healthcare systems in the West in that sense than it was staying back home."[656]

Arjay N., an Indian-educated internist, describing his experience 40 years earlier, in the late 1960s, described these same contrasts between educational expectations and clinical reality. He too felt in many ways better prepared to practice in a Western setting, describing the "satisfaction," of practicing medicine as he had learned it:

> What you learned you couldn't practice at those times in India. You just learned something in textbooks, but none of them were available, the resources were not available. So medicines were not available so you would say*: this is what you should do to treat, but this is how you would manage.* So once you came here and you saw that you could come close to what you are learning, yeah that was a part of the satisfaction as well.[657]

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654 Sofia S. interview with author, February 2015.
655 Laila A. interview with author, November 2014.
656 Laila A. interview with author, November 2014.
657 Arjay N. interview with author, January 2015.

In Dr. N.'s medical education, the contrast between what he *could do* and what he *should do* for patients was ever-present and openly acknowledged. Part of describing patient management was to explain how a patient should be treated, followed by how to adapt that approach to what was available. According to Wendland's ethnography, conversations like this were a daily feature of rounds in a Malawian tertiary care hospital—where the absence of antibiotics, testing modalities, or nursing care were a regular factor in patient management plans. As one attending reminded his interns, "this is not normal."[658] Many of the medical students Wendland followed found these daily reminders extremely painful, and constructed different responses to them. Most became angry and disillusioned with their government; others became disillusioned with medicine as they were able to practice it. Comparing themselves to "medical tourists," medical students that visited their hospital from Europe and North America, some students "created a concept of the doctor as unmarked global citizen. From there it was a short step to seeing medicine as a necessarily expensive and high technology endeavor, and Malawian medicine as somehow less than real or second rate."[659]

Majid F., who trained as an Internist in Egypt in the 1970s described coping with his sense of the growing dichotomy between the medicine he learned and the medicine he was able to practice by looking to a national and personal progress narrative:

> In medical school I thought…you have to do things by the book. I found this to be completely different when you practice. …sometimes patients need certain medicines…not available. We would have to discharge patients from the hospital before we were supposed to or refuse to take patients into the hospital because of some other issues… in 2 years of residency in Internal Medicine I learned a lot, but at the same time you're working like a dog. I mean…most of the time I just

[658] Wendland, *A Heart for the Work*, 183.
[659] Wendland, *A Heart for the Work*, 135.

> stayed in the hospital overnight especially when I was on call. But as I said, the resources are limited and I thought this was going to improve. I thought, this now may be a good time, things will improve. But I then I become faculty and as an instructor there things were still the same.[660]

Dr. F. decided to immigrate to the US when a series of events triggered a sense of disillusionment in both the healthcare system's ability to provide for patients, and it's failure to treat him fairly as a clinician-scientist. He remembers, "I made the decision to leave my country to come here because what you learn in medical school is not applied." For Dr. F., the watershed moment came when the structural impotence he felt on behalf of patients extended to himself as well. As he describes, it, "this is actually what made me decide to come to the United States. When I was a senior instructor, that was around '75, they send me to (East) Germany to work on Schistosoma because Schistosoma is a kind of worm which is very common in Egypt," while he was there, his mentor died and he got pressure from other professors to turn over his results for them to publish. "I found that you can work so hard…and someone can take it away from you and claim it for himself and I said *no, I'm not going to do that*… And then I thought, ok this is not my place I have to leave and then I started sending applications and my credentials…"[661]

Like Laila A.'s experiences of working in Pakistani displaced persons' camps, perceptions of corruption and structural dysfunction were sometimes more frustrating to Majid F. and other clinicians I interviewed than even the most acute resource limitations. For Laila A. and Majid F., perceptions of inaction or mismanagement on the part of those who also have duties to their patients, whether they be administrators, other physicians, or legislators and politicians often led to a deep sense of structural impotence. Abraham Verghese's narratives which open this chapter are rife with examples of young physicians

[660] Majed F. interview with author, February 2015.
[661] Majid F. interview with author, February 2015.

chaffing against corruption and cronyism in what they perceive as oppressive hierarchical training systems. Situations that leave young physicians feeling that they are compromising patient care violate the central values of medicine and compromise physicians' perceptions of themselves. Encounters with corruption and cronyism also violate the unspoken meritocratic ethos of medicine—which, shared with the ideals of other scientific fields, purports to reward intelligence and hard work. In Wendland's ethnography, her participants' greatest ire was directed at corrupt administrators and politicians. Although they were willing to make sacrifices for the good of their country, "they did not want to be fools or pawns." For her participants, "when self-sacrifice was too unjustly demanded," or "the experience of injustice was too sharply felt," migration often became the answer.[662]

Thus for many of my interviewees, the dream of American medicine encompassed essential elements of physicians' identities they felt were frustrated by resource limitations. Physicians defined their identities differently, however. For Karthik R., educated in India and now a family physician in a small Midwestern town, access to technology was essential to his identity in medicine and a major draw of the United States. In his words, "here you see lots and lots of advanced technology. So CT is easily available, MRI is easily available, there are lots and lots of new genetic tests we can do here…To go to a residency program or just to practice here in the USA is very, very advanced."[663] For many other interviewees, however, access to technology was a part of a larger picture—the ability to take care of patients in what they saw as the best way possible: in the ways their training had prepared them for. When I asked my interviewees

662 Wendland, *A Heart for the Work,* 205.
663 Karthik R. interview with author, July 2014.

how they defined a good doctor, and whether their definitions changed in the US, the answers I received were fairly consistent. "A good physician, should be a physician wherever he goes… in any part of the world," "I think the qualities are still the same, you look out for the best interests of patients."[664] [665]Another summarized, "care for patients, listening to the patients, would be something to start with, good knowledge, or great knowledge."[666] Some expanded on these ideas, describing medicine as a fundamental identity, in the words of Adnan R., a Canadian physician trained in Hungary: "It's not a nine to five thing... I don't think doctors ever stop being doctors until they retire and then they're still doctors. So it's something that's 24/7…it becomes ingrained in one's identity. We spend so long doing it, it becomes who we are as well."[667] Laila A. also sees clinical medicine, and particularly the clinical encounter as fundamental to her identity:

> I think if I were to go into health policy I would always have a clinic or two where I would just see patients…I've attempted to do just looking at the numbers or just looking at maternal mortality—it overwhelms me, just the numbers, it overwhelms me—I need that one-on-one connection with a patient and to know that so, OK, I can't fix that number of 276 (maternal mortality rate in Pakistan), but at least I made a difference in this one person's life today even if it's just a cough or a cold.[668]

Thus, decisions to migrate are interwoven with complex and sometimes contradictory notions of medicine as an identity and notions of what it means to be a good physican. Juan P., who trained as an internist in Mexico and now practices as a family physician in a growing US-Mexico border city described the promise of treating patients without external restrictions as a powerful motivator for coming to the US:

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[664] Karthik R. interview with author, July 2014.
[665] Adnan R. interview with author, July 2014.
[666] Mateo N. interview with author, July 2014.
[667] Adnan R. interview with author July 2014.
[668] Laila A. Interview with author, July 2014.

> I [had] some friends over there (in the United States) and they say that it's pretty good, that there's a lot of opportunity for us and that you can practice the way you want. Not really the way you want, but you can do a lot of things for your patients because the resources are just great over there. In Mexico it wasn't like that, we're a poor country, so it's very hard for doctors to practice and get everything done. Whatever you order it takes a year, over there.[669]

Esther L., an East-African trained internist found a somewhat different way to frame migration in terms of her identity as a physician. For her, the choice to train in the United States was a way to become a certain kind of doctor—one she felt she could not become in her home setting:

> For me the people who mentored me or who were my faculty I did my internship with influenced my decision… The physicians who I worked with…in the mission hospital… I don't know if it's because of the schools they went to, a lot of these physicians went to, you know, Hopkins or Ivy League schools … and I don't know if it's just a work culture with them, but … what influenced me about these people was just how hard working they were how they care for their work with their patients. You know they didn't sleep if a patient was in the I.C.U… it wasn't something that I was used to because the physicians that trained me they came whenever they came. Or the resident or the student would take care of the patient and if they died they died you know, "moving on." So there was that difference I found that … I mean that the American tradition that trained me during my internship was that extra level of caring. I don't know... I think like I said my experience might be a little biased because that's who I worked with…[670]

Esther L.'s description, quoted at the beginning of this section, of the time pressures on clinicians in East African public hospitals highlights clinical time, time with patients, as the most precious and endangered resource in that healthcare setting. In her analysis, the matter-of fact, and sometimes apparently callous attitude of her East African attendings could be traced to these fundamental pressures: "the volume of the patients just to be honest doesn't allow that level of attention. Number two, I think it's just really the culture that's being passed down -- this is how you grow up watching the older physicians doing…and that's how you do it when you finish training." Thus the ability to develop

669 Juan P. interview with author, July 2014.

670 Esther L. interview with author, January 2015.

the attentive ethic of her American mentors was perhaps the greatest luxury of American medical practice. For her, the American medical dream was simply having the time to care for patients, the ability to have confidence in having attended to their medical needs. She describes enjoying her preventative medicine residency—learning about primary prevention and the treatment of chronic conditions. These were aspects of medicine that seemed distant to her as a clinician mainly focused on the enormous needs of basic HIV care back home. When I spoke with her, Dr. L. had not yet decided whether she would return home or remain in the US, but, she felt, wherever her career took her, she had become a better clinician by seeking out this perspective.

The caring ethic that Esther L. describes in her elite-trained, American attendings is not necessarily an ethic of empathy or focus on the less tangible aspects of the doctor patient encounter—though this is not to say her clinical mentors did not also display these traits. Rather, care, in the sense she is using it, is thoroughness, a rigorous attentiveness to the patient's medical needs. Katherine Montgomery describes this as one of the moral values, clandestinely labeled at scientific, that are woven into the fabric of much of medical training. Thus, the "entwined…ethics and practice" of clinical medicine, pushes its' learners to value "attention to the patient, reliance on one's own perceptions, awareness of one's skills and limits, careful observation, thoroughness, and accurate representation of what is seen and done."[671] In seeking to emulate the ethic of care of Western mentors, Dr. L., in Pellegrino and Macintyre's words, is seeking goods internal to the practice of medicine, at least in the ways the practice has been defined by her training, and striving for certain excellences as a clinician. In her perception, however,

[671] Montgomery, *How Doctors Think*, 159.

she could not gain these moral excellences in a resource-limited environment, especially if the most limited resource is the ability to give time and attention to patients.

Majed F., who changed his specialty from internal medicine to pathology after immigrating to the United States, also equates the pursuit of the moral and the technical virtues of medicine in his repeated emphasis on practicing medicine "by the book." Like Esther L., he feels like this can only be achieved outside of his home training environment. When I asked him about identity, if he saw himself as American or Egyptian he responded, "In my work I'm American here and there. My life is a little bit different." He follows up this statement by explaining that to him being "American" in his practice, is being able to maximize his diagnostic rigor, something he feels was difficult in the resource limitations and practice culture of his country of training.

> My colleagues who are professors there, they maybe tolerate the situation over there … as I said I'm the kind of person that likes to do things the right way. I don't like shortcuts and I will not compromise… I tell my residents "you as a physician you are the pathologist you have the surgeon and you have the patient…which one is in the weakest position here?" The patient! Because he gives his soul…so you have to be trustful, you have to do it right for the sake of the patient and also for the sake of the clinician.[672]

For Dr. F., emigration was directly tied to his identity as a physician, and his desire to be a particular kind of doctor. For him, medicine is a profession of demanding clinical and technical rigor in the service of patient care. The promise of American practice was tied up with the desire to feel he could escape the messiness of local politics in the clinical and professional aspects of medicine.

Most of my interviewees entered medicine at much younger ages than the typical American medical student. Training models ranged between 5 and 8 years, and most

[672] Majid F. interview with author, February 2015.

chose medicine as a career path by the age 16 or 18 and were physicians by the age of 25. Thus, entering medicine was often not their decision alone, but involved parents and families. Several of my interviewees made it clear that their decision to be physicians was heavily influenced by external goods such as the possibility of migration, income and status. For many others, however, the desire to enter medicine was based on perceptions of medicine as an intellectually stimulating practice with its own rewards as well as by medicine as a social good. Reasons for migration to the United States, and other rich countries were often complex, but consistently tied into motivations for pursuing medicine and identities as physicians. Thus for my diverse group of interviewees, ranging greatly in age, medical specialty, and cultural background, migration was mostly, or at least partly, tied into the desire to become "good" physicians. Ideas of what it meant to be a "good" physician varied, but shared a common theme of being able to provide good care for patients. For some, it became increasingly difficult to see themselves as a good physician in their home setting, and for them the response was to migrate someplace where they could practice "real medicine," "by the book," and escape the stresses of doing the best they could with inadequate resources. Interestingly, the resource limitations my interviewees faced varied greatly, ranging from trying to treat patients while lacking clean water, to lacking medications, to feeling like they were making patients wait too long. There was not necessarily a predictable relationship between the level of limitation and what an individual clinician would find intolerable.

Not all of my interviewees focused exclusively on the individualistic ethic of the doctor-patient relationship, however. Several expressed a desire to balance giving good care to individual patients with a sense of responsibility to the patients and populations of

their home countries. Describing experiences of structural impotence, situations where they realize that the curative care they provide is merely bandaging illnesses with deeper social roots, clinician-interviewees sought empowerment by either leaving these situations altogether, or by reorienting their identities, seeking knowledge, skills and roles that would allow them to understand and address the broader situation. The later path was less common, and often presented a number of challenges. For some clinician-interviewees this meant radical career-reorientation. David T., who pursued medicine in Botswana before that country had a medical school, was sent to train in Australia by his government. He described his return home to practice as initially distressing and chaotic—6 years of medical school in Australia had done little to prepare him for illnesses and sheer volume of patients he would face in his home country. He felt his feelings of patriotism for his country and its people, however, helped him work through the shock of return. When I spoke to him, he was in US temporarily, working on a degree in public health, intending to return not just to practice, but to work on a systems level, organizing public health work and becoming involved in a project to start a medical school and residency program in Botswana.

Laila A. described her experience working with women in Pakistani displaced-persons' camps as the turning point that led her to radically re-orient her career. In many ways, however, this re-orientation was painful and personally frustrating. Recalling her time in Aga Khan University, she felt that as medical student she was on a particular path, "I was really invested in the OB/GYN tract up until that point, I wasn't even thinking of family med at all. You can imagine with a competitive med school that is not the specialty people go into. You were going to do GYN/ONC you know…" As a

medical student, she also discovered a passion for surgery, recalling, "I was the first to scrub in and the last to scrub out." Directly after medical school, she decided to apply to OB/GYN residencies in the US and the UK, explaining, "It was peer pressure, all my friends were applying, 70% of my class was here." She continues,

> My mom's an OB/GYN there (in Pakistan) so she insisted that I actually spend a couple of months in Pakistan working in a government hospital or somewhere like that before coming here because she said: "your understanding of healthcare in the East is very much like that of someone who would directly be supplanted from the West or read something from a book"… So it actually started off as two-three months working in a refugee camp… it was just one project after another after another and I ended up spending three years there. I think I really got burned-out by the end of it and that's when I decided to come here and do family medicine.[673]

She describes a "definite shift" after her time working in the camps. "Just all these women that were coming… the husbands would just bring their wives or their mothers or their sisters or their daughters to the female doctor…so I was being made to deal with diabetes and high blood pressure, so I said, I might as well be trained in this instead of in the ad hoc manner in which I'm doing it, because if I missed it then that was that." This experience challenged her to embrace a more holistic definition of women's health, not "restricted to her uterus," but including her "diabetes, hypertension, a swollen ankle …even depression…" and extending to her social well-being and the health of her children. Dr. A. also attributes feeling "burn out" to her sense of impotence in the face of the enormous public health problems facing her patients in a time of war and mass-displacement:

> I just felt, great, you've looked after this lady, you've delivered her baby and you've done it in the best way possible, how is that going to change the maternal mortality rate of Pakistan? It isn't. We're still going to have one of the highest rates in the world at 276... There was absolutely no excuse, I feel that

[673] Laila A. interview with author, November 2014.

> internationally it is perhaps Pakistan's biggest scandal, our maternal mortality rate, not the terrorism issues or whatever else, that is to me our biggest issue.[674]

Her education and practice, she realized, was "missing this huge public health component," and she found herself devoting more and more of her time to training midwives to work in the tribal areas, hoping to begin to address the problem. As she realized, truly helping these women, something that she felt deeply about, meant a more holistic approach to their health, an awareness of their public health needs, and finally, advocacy for them on a policy level. Confronted by overwhelming structural challenges in her ability to provide the best care possible for patients, Laila A. is an example of a physician who, faced with the inability to fit her own definition of a good doctor fundamentally re-defined her role. Part of achieving these goals, she discovered, however, was migrating, at least temporarily, to the United States. In her words, "for me I think sort of the tipping point where I decided to go to the US or wherever else was to sort of understand things better or get an MPH or actually get a family medicine degree, because you may feel very, very passionately about things but if you don't know how to execute a plan it just remains, just that, you know." The choice, however, was bittersweet, and although she does not regret switching to Family Medicine or pursuing public health, "it was a little bit naïve," she reflects, "I didn't realize how much I would miss the OR."[675]

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674 Laila A. interview with author, November 2014.

675 Laila A. interview with author, November 2014.

WHY THE UNITED STATES?

Cumulatively the stories of these physicians combine to sketch out some of the complex and protean forms of the American medical dream. In often very different ways, training or immigration to the United States comes to represent what was missing for each of these physicians in realizing their conceptions of identities as doctors. For many, the contrast fundamentally comes down to resources, whether they be defined as educational opportunities, basics such as running water and medications, advanced technologies such as MRIs and genetic tests, or something that is often not recognized as a resource at all until it is missing: the time to care for patients. The emphasis on resources, however, begs the question, why the US in particular? Why not travel to any resource-rich country with a demand for physicians, for example Canada, the UK or Australia. Are there particular ways that these physicians envision the United States that specifically inspire them to migrate? Geographer John Connell, in his exhaustive survey of global physician migration describes the processes by which physicians migrate as "carousels," "chains, steps, and networks," complex paths that health workers from low and middle income countries as well as from the rich world follow in their choices to migrate.[676] As he asserts, "the USA is the alluring ultimate destination" of many of these flows, though he does not elaborate as to why.[677] Perhaps he sees the answer as obvious—that the world's largest economy would offer the most opportunities and highest remuneration. As Verghese's observations, quoted at the beginning of this chapter intimate, however, the pull of the United States is perhaps related to these reasons, but also has particular appeal to physician migrants, promising a particular ideal

[676] John Connell, *Migration and the Globalization of Health Care*, 57,59.
[677] Connell, *Migration and the Globalization of Health Care*, 63.

of medical practice. As powerful as the appeal of higher pay and professional opportunities, are the promises of technological advancement, therapeutic plenty, and a relatively meritocratic professional structure, where particularly as a physician, "your talent and hard work can take you to the very top." Mateo N., who came to the US in the 2000s and entered a family medicine residency, echoes some of these sentiments as he describes emigration as another step in achieving the excellence instilled in him in his medical training, to become a "better doctor":

> My thoughts were that the US was the number one place to practice medicine, to do medicine, to learn medicine. All the information, a good amount of information comes from the US, all the studies, you know and all the good hospitals. And I think that was all in my mind that I still wanted to come to the US and try to be…try to be a better…those were my thoughts, I mean you can be a better doctor anywhere, you don't need to be here in the US. But on the other hand I saw that I would have better opportunities, better resources, to become a better doctor here in the US.[678]

The American medical dream is of course, entangled with broader ideals about life in America, popularized by mass media for generations. During the Cold War era, state department efforts served to portray the US in a particular light, especially to residents of the contested "3rd world." As Majid F., who immigrated to the US from Egypt in the late 1970s, had dreamed of experiencing life in America since childhood:

> Since I was a child…the Western movies, the brainwash. So one of the places I always thought I would love to go is the United States…I used to study in the American consulate. They had a big library…I was amazed, it was as if I'm in heaven, I go there, whatever I needed, textbook or atlas or whatever, is available and I sit and study there… I saw the system and how neat and clean things are, things were done by the book, and the people were nice. So I said *ok I think that's where I'm supposed to go* when I was in medical school.[679]

Karthik R., who immigrated from India in the 2000s, expressed similar views about American life in general as about American medicine, describing is as "more

[678] Mateo N. interview with author, July 2014.
[679] Majed F. interview with author, February 2015.

organized…well regulated," in contrast to the contingency and chaos of "a third world country." Like Majid F. who grew up in Egypt in the 1960s, David T., growing up in Botswana a generation later, found that his early ambitions to pursue medicine were entangled with exposures to American culture:

> My mother was a nurse and she worked in a mission hospital. In that mission hospital we used to interact with the missionaries who came over … there were no local doctors, there were just people from outside. One of the doctors … his wife was a musicians who taught piano so I went for piano lessons…she had all these books and she used to encourage us to read and all that. She had this book that she shared with us, there was a group of us guys, and then I read this book and I just believed that I could do that – I believed I could be a doctor. The book was by Ben Carson, *Gifted Hands.* So from then I just thought this was it, this was what I wanted to do and it was also … and I thought it was achievable so that's where my interest really started…[680]

Dr. T.'s story is rich with cultural ironies. Growing up, he saw doctors as "people from outside." It was through the influence of Americans, in this case the missionary physicians and the literary representation of Ben Carson that he could come to see himself, as a Motswana and as someone who could aspire to be a doctor.

Other comments from the physicians I interviewed hearken back, often subtly, to legacies of colonialism and educational development work. As the previous chapter discusses, through efforts of the Rockefeller foundations and other, mostly American-based philanthropic organizations, medical education has been an increasingly globalized endeavor for several generations. One of the more overt signs of this is the language of instruction. At least half of my interviewees described their medical schools as being taught fully or partly in English. Just the fact of familiarity with English mobilizes physicians looking for resource-rich environments in certain directions. In Laila A.'s words, "you've taken a bunch of high achieving, highly competitive kids who want to go to the best place in the world and yes, the best universities right now and medical centers

[680] David T. interview with author, January 2015.

are in this country …as bad as the insurance system and everything might be. Cutting-edge work, still a fair amount of that gets done here. And another place where a lot of that happens is maybe Germany or France, but guess what, we don't speak French or German."[681] Several of my interviewees had considered training in the UK, or described experiences of friends that had done so, and a few had considered it as a second choice. Many however, described the system of training as stratified and hierarchical. In the words of one Jordanian internist, "they have a certain number that can't transfer from one position to another position. So you can stay in a junior spot for two years or three years."[682]

AMERICAN DREAM OR AMERICAN TRAP

Amir H., who graduated from King Edward Medical College in Lahore in the late 1960s and now practices as a surgeon in a South Texas estimates that of his graduating class of 200, approximately 50 went abroad.

> The final year we were all talking about going abroad to get an advanced education. At that time everybody's intention was that we would go get postgraduate training and return; to come back and work back in Pakistan. But that really didn't work out…not only because of finances but politics, economics, hospital systems.[683]

Of the thirteen physicians I spoke to, only one came to the United States with the unequivocal intention to immigrate. Over the years, however, six have decided to establish their personal and professional lives in the United States and three are currently completing J-1 visa waivers in underserved areas in order to make immigration a possibility. Even among the three physicians who came to the US with a crystal clear

681 Laila A. interview with author, November 2014.
682 Faris T. interview with author, January 2015.
683 Amir H., interview with author, February 2015.

intention of going home, two have begun to question their original plans, and debate longer stays, if not permanent relocation. David T. sees Western medical training as a potential "trap" for the physicians from poor and middle income countries that seek it out. Although many of his fellow Batswana physicians "had good intentions to stay and do the training and go back," The dreams that bring physicians to US and other wealthy nations are less ambiguous and complex than the realities that these physicians find once they get there. One of the ironies of American medical training is that migrant physicians find what they come looking for—the ability to be American physicians and practice American-style medicine. It is precisely the ready availability, even the overabundance, of diagnostic and therapeutic resources that impairs clinicians' ability to return to previous skillsets and values in delivering care. Additionally, those who migrated with idealistic intentions of achieving advanced training they could bring back and apply in their home countries often found unexpected personal and professional road blocks both in leaving the US and in returning to the healthcare systems of their home countries.

Laila A., for example, originally planned to complete a three-year residency in the US, perhaps with an additional two years for fellowships before returning home to Pakistan. Now completing her residency, she was seriously considering pursuing further training or applying for a waiver position. Some of her reasons for prolonging her stay were personal and context-dependent. With increasing violence in her home country, her father, also a physician, who had previously encouraged her to return, felt that he would "sleep better at night knowing that at least one of my children I don't have to worry about constantly…" For her, "there is that huge dilemma to deal with, so I don't think I'd ever completely cut off…but completely stay there all the time, I couldn't quite do that either,

and I'm not sure if it's because I've changed or if I'm attempting to defer to what my dad wants." Ironically, she felt that the biggest difficulty in returning home was the training she had traveled here to get. As she explains, "I honestly did not realize that as great as it is, you get restricted just because of your training, your training becomes your biggest handicap in many ways." Although her American training taught her to use advanced medical technologies, it actively dis-incentivized the maintenance of basic clinical skills, so crucial to functioning in low-resource environments. She emphasizes, "you cannot be a global doctor once you are trained in this system, you can't."[684]

> I know for a fact my physical exam has deteriorated since I've come here. You know in a sense that yes I listen to the lungs, but before I used to listen carefully, because I knew that if I missed something this was it. I couldn't do a mass x-ray on every patient that was walking through the clinic. Now I'm like, *whether I say it or don't say it, we're going to do an x-ray anyway*. Now is my exam that great? If I listen to a murmur am I actually going to make the patient sit up, get down, no, I'm going to do an echo.[685]

At the time I spoke with her, Esther L. who was halfway through her first year of an endocrinology fellowship in a Houston hospital was also at a decision point. Although she had started her US training with the goal of increasing awareness of preventive care and chronic diseases in Kenya, she was beginning to wonder if simply returning home as a clinician was the best way to move these goals forward. Now that she has fairly advanced sub-specialty training in endocrinology, "it's not a matter of saying *I'm done, let me pack my bags and go home*." Although she is open to it, she realizes that returning home would be a huge adjustment and would require careful planning among many unknowns. In her words,

> You know it's not easy to just come in and fit in just because you were educated in the US you think they're going to welcome you with open arms that sort of

[684] Laila A. interview with author, November 2015.
[685] Laila A. interview with author, November 2015.

> attitude…… I wouldn't call it… it don't know what the word it, but people are not always as receptive as you would expect them to be because you went and you got and education outside of your country. So there's always, and again I don't know what the right word to use is … I don't think its resentment, I don't think its complication…[686]

Concerns about fitting in to the sometimes jealously-guarded hierarchies back home also affected Arjay N.'s choice not to go back to India in the mid-1970s.

> My plan was to study and go back, but then reality was I could never join with the level that was commensurate with my training. So if someone else had joined for a job in India at that time before I did, even though I had done more than five year of training, I'll have to join as a junior to the other person.[687]

Amir H. felt that many of these same barriers kept him from returning to Pakistan when he finished his training as a surgeon in the early 1970s.

> … the system over there is … point blank, it is corrupt. So if I were to go back and I were to get a job as in a teaching institute professor or whatever of surgery a lot of times it requires mainly two things—you've got to know the higher up parties and some way to get you the good jobs. And from the very beginning I was not interested in anything like that…so I said *well I'll stay where at least my work is rewarded, my work is appreciated…*[688]

Ether L. described a sobering process of self-assessment, attempting to figure out how she could integrate her subspecialist training into a resource-poor environment. Though there is no lack of need for her expertise, one of her first challenges is that the Kenyan healthcare system does not have a structure for continuity of care, something essential to her emphasis on chronic diseases. "Am I going to have my own private clinic? Am I going to join an academic institution? There's all those little things to consider and it's not always … the academic institution if that's something I'll be interested in, I don't know if it's even open, I don't know where I would fit in." Clinically, "when I've been

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686 Esther L. interview with author, February 2015.

687 Arjay N. interview with author, January 2015.

688 Amir H., interview with author, February 2015.

thinking about going home I certainly won't be able to practice the level of endocrinology that I have practiced in the U.S. that's a given." In trying to create a space in which she will be relevant back home, she may have to give up the use of knowledge and skills that she has worked hard to build:

> It makes me sad because I guess I could teach what I learned about endocrine, but suddenly I couldn't do some medicine, for example, I couldn't do adrenal. What would I be doing? …But when I think about going home I think it's nicer because I will be one of the only specialists. People will look up to me I will be able to teach and that will be all good, but actually practicing I don't know. I don't know how relevant all my experience and practice would be.[689]

In her residency training in preventive medicine and her subspecialty training in endocrinology, Dr. L. also developed an interest in research. One of her career goals is to do research on health needs in her country, something her country can't afford, but that she feels is necessary "in order to be able to progress."

> I'm coming from a research background you know my…right now I'm doing research. I'm applying for grants by myself. The reality is at home there's just nobody who can afford research. The government is not going to give any money for research so you have to fend for yourself …If we're going to progress in any way at home we have to do our own research and show them what issues they're having at home. So I think the best way to get to a point like that where I'm able to do research in an African country, back in my country, is to have partnerships or collaborations…"[690]

She envisions an ideal future practice that would allow her to have "one foot here and one foot back at home," describing a position her American colleague negotiated at Duke with 20% time in Kenya. Her situation highlights an interesting irony, the only way an African physician could really envision doing research on African health needs is, essentially to become an American.

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[689] Esther L., interview with author, January 2015.

[690] Esther L., interview with author, January 2015.

Like Laila A., Esther L.'s constraints about going home or staying in the US are personal and circumstantial. As a mother, she feels she needs to think carefully about uprooting her children and her husband. Remarking that her son is about to enter the second grade, and her husband needs to be near a major airport for his job. Thus, choosing to stay in the US is also not an easy decision. She remarks,

> It's stressful the way that you have to look for jobs earlier, either you're going back home or you're staying, there's a lot of people that's involved in the process and a lot of deadlines that each state has for the waiver program… The thing I am not going to do is- I am not going to go to an underserved area that basically isolates us in the middle of nowhere, where I don't have good education for my kids and my husband travels a lot for work if we are two hours or more away from an airport – I'm not going to do that. If that's where the jobs are available and it's just unsuitable for our family we are going to go back home.[691]

Dr. L's situation as the parent of a young family is also indicative of some of the forces that often lead to IMGs staying in the US. Most of these physicians are young, perhaps in their late 20s or early 30s, the prime age for getting married, starting a family and putting down roots. For Arjay N., the final straw that resulted in his decision to stay in the US was his marriage to a woman who suffered poor health in India. Wei Z., a pathologist originally from China, also considered his son and daughter when he decided to stay in the United States after his PhD program and start the process of exams to apply for residency.

Like any ideal, the American medical dream can be both inspiring and tyrannical. Although the initial culture shock of adjusting to American medicine was challenging for many physicians I spoke with, return home often proved to be an even greater challenge. Although perhaps not fully adjusted to American culture itself, these professionals quickly became American physicians in important ways. It seems making the decision to

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[691] Esther L. interview with author, January 2015.

stay in the US, even more so than the initial decision to leave home, stimulated deep and often insightful reflection on roles and contrasts within healthcare systems and sometimes on larger structures of power and inequality. These choices sometimes make clear the ironies of American training, and the perverse ways in which it complicates if not precludes meaningful return home. The experiences of my interviewees are likely to be reflective of larger realities—although rates of return are actually somewhat difficult to calculate, some researchers have estimated that 70% of IMGs who train in the US end up making their careers here.[692] This is particularly ironic given that a large number of physicians come to the US on a J-1 visa. As pervious historical chapters have detailed, when created in the post WW2 era, the stated intent of the program was one of generosity to the "less developed" countries of the world—providing advanced education and skills that learners could take back to contribute to the progress narrative of their home countries. Very quickly, however, it became apparent that the system worked in the reverse direction just as often, helping US healthcare clandestinely satisfy its labor needs, while often not admitting these needs even existed.

As discussed in chapters 2-4, rhetoric within the US often portrayed physicians who left their countries for the US as selfish and unpatriotic, leaving places of greater needs for "greener pastures." Many earlier discussions on brain drain were motivated as much by local antipathy toward a perceived influx of foreign physicians as to genuine concerns over the well-being of their countries. More recently, brain drain and the migration of healthcare workers has once again garnered attention. Many academics cite dire statistics about physician patient-ratios in developing countries that become the

692 Mullan, Fitzhugh. "The Metrics of the Physician Brain Drain." *The New England Journal of Medicine* 353, no. 17 (October 27, 2005): 1810.

source nations for many medical migrants.[693] The blame, implied or stated, often falls on clinician-migrants and the rich-nation healthcare systems that recruit them. These narratives can de-emphasize the deep systemic problems that plague poor nations healthcare systems, ranging from overwhelming clinical needs due to diseases of poverty, to political instability, to corruption, to the pernicious effects of economic restructuring imposed by development agencies such as the World Bank and the IMF. Adding the voices of a small group of physician-migrants to the US reveals these critiques to be somewhat simplistic. Detailed personal narratives about why clinicians migrate help encompass the textures of experience of this group of clinicians, to once again borrow Kleinman's term. These people work within a complex matrix of obligations to family, to self, and to medicine itself. They do think, to varying degrees, sometimes very deeply, about the ethical implications of their choices. As individuals, many realize that their choices are constrained by their own positionality and larger structures of economic inequality. Discourses that make physicians personally responsible for physician disparities often overestimate their roles in healthcare systems deeply troubled in so many other ways and underestimate their own engagement with these questions. In Wendland's words, the stories of these physicians portray them as "ordinary human beings, struggling to make difficult decisions where there is no morally clear option."[694]

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693 Mills, Edward J, William A Schabas, Jimmy Volmink, Roderick Walker, Nathan Ford, Elly Katabira, Aranka Anema, Michel Joffres, Pedro Cahn, and Julio Montaner. "Should Active Recruitment of Health Workers from Sub-Saharan Africa Be Viewed as a Crime?" *The Lancet* 371, no. 9613 (February 2008): 685.

694 Wendland, *A Heart for the Work*, 32.

Chapter 8: Critiques from the Margins: What We Can Learn from IMG Experiences of US Health Care

One of the questions I asked my research participants was about the challenges of adjusting to working in the US healthcare system. A common theme in these answers, much as in comments about leaving home, was the availability of resources, but also the culture of making use of them. As one East-African physician described her initial impression of the US healthcare setting:

> Yeah when I came in… simple things like having gloves, you know at the station or wherever, you know you get the gloves and sometimes you would pick up the glove from the floor and throw it in the trash. For me I was like *wow! wow!* You would just throw gloves away just like that you know…. I would go to the sink and I would wash my hands and I would use a single paper towel to dry my hands up and I'm looking at all these people washing their hands and using three or four paper towels to wipe their hands… and I'm like *gosh these people are so wasteful*, given the fact that at home, first of all, if there was water in the tap you could wash your hands. Otherwise you had to walk around with your small hand sanitizer in your pocket. I was of the mindset that people are very wasteful. I guess it comes from the background of knowing there's always existing resources and they don't know otherwise.[695]

Several interviewees articulated the appeal of practicing in the United States as an opportunity to "practice the way you want."[696] This expression, which I refer to as the American medical dream in the previous chapter, often meant the availability of resources to do what they felt was appropriate for their patients. Juan P. saw coming to the United States as something that would empower him in his role as a clinician. To some extent his expectations were met—another physician, Arjay N., described the "satisfaction" of being able to "come close to what you were learning" amid the plenty of

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[695] Esther L. interview with author, January 2015.

[696] Juan P. interview with author, July 2014.

US healthcare.[697] As several of my interviewees found, however, in the American environment the clinical empowerment they sought was sometimes constrained by this very same abundance.

As my interviewees described it, the process of adjustment to working in the US could be surprising and at times distressing. In the course of the interviews, participants shared with me the aspects of the US healthcare system that they found the most difficult to adjust to. In so doing, these physicians, many of them relatively mature clinicians who had practiced in two and sometimes three healthcare systems, offered some cogent critiques of medical practice in the United States. A common thread that linked many of their concerns, exemplified by ML's comments above, was blatant and baffling waste within the system. As they became socialized into American practice styles, these physicians describe feeling constrained to make choices that they initially saw as inappropriate and wasteful. The physicians I spoke with contrasted their US experience to work in countries that varied greatly in the clinical resources available to physicians. For Esther L., practicing for several years in a mission hospital in Kenya, or for Arjay N. who trained in an Indian public hospital in the 1960s, the contrast was perhaps more striking than for Adnan R. who trained in the US but currently practices in Canada. Each of them however, commented on the factors that led to their perception of waste in the US system. Some of the concerns these physicians bring up are not unfamiliar to many American-educated and trained clinicians. I suspect a random sample of USMGs would also bring up concerns about defensive medicine, out of control costs, and the fallibilities of the health insurance system. Critiques by IMGs however, may be uniquely valuable:

[697] Arjay N. Interview with author, January 2015.

ostensibly triggered by a variety of issues such as defensive medicine, access to healthcare, and the positions of IMGs in American medical practice and training, the common theme of these concerns centers on the idea of resources and waste. Read together these narratives reflect back on the ways the US healthcare system socializes physicians, both blatantly and subtly, to practice medicine in particular ways- ones that lead to a perverse relationship to the relative availability of clinical resources. Though many of my interviewees felt conflicted about taking on these lessons, they also commented on the culture of American medical training and how these changes sometimes felt inexorable. In so doing they demonstrate that there are indeed alternatives to this style of practice that don't sacrifice a patient-centered ethic.

This chapter speaks to two bodies of literature in American medical education and Health Policy. Curtailing waste and the overuse of resources has been a recurring theme in US health policy discourses since the 1990s. It is a debate infused with political stakes and rife with ideological battle lines. Although policy commentators have suggested many approaches, most center on different ways to alter physician behavior—often with limited success. The last two decades have also seen an increase in articles in publications such as *Academic Medicine* about "acculturation," or "practice socialization" for International Medical Graduates. In this literature, these terms are normative rather than descriptive, acculturation is presented a positive goal to be achieved. These bodies of literature are rarely read together, yet interpreted with perspectives from interviews with IMGs, they can speak to each other in novel ways. Thoughtful commentary has located the waste and skyrocketing costs of US medical practice in a variety of structural factors, including American practice culture. The practice norms some IMGs struggle

with most can be a valuable critique of these norms themselves. Powerful acculturation pressures can dull this critical edge, however. Although in a practical sense, facilitating the ways in which these international physicians adapt to American medical practice is a laudable goal, the dominance of this discourse can curtail a conversation about what their diverse perspectives could truly add. Thus, once again borrowing Kleinman's terms, attention to the textures of their experiences re-training in the United States, as well as the perspectives they develop as clinicians on the margins of multiple healthcare systems and between conceptions of their roles as physicians can lead to broader insights into these conceptions and systems themselves.

As discussed in the historical chapters of this project, concerns about the disproportionate and growing costs, both public and private, of the US healthcare system, have haunted policy makers since the "crisis of medicine" of the 1960s. Awareness and concern about this question, however, really grew to prominence in the late 1980s and early 1990s, with sequential controversies about rising health costs, the Clinton administration's ill-fated health plan, and concerns about the expansion of managed care organizations.[698] The roles of physicians in burgeoning costs as well as their potential roles in curtailing the problem have been particularly hotly debated. Legal scholar Mark A. Hall, writing in the late 1980s, described "institutional control" of physician choices as a novel and controversial way to cut costs.[699] As a 1978 piece by Edmund Pellegrino demonstrates, however, since the inception of the cost-control debate, it has been entwined with fears that such concerns would conflict with the "traditional morality of

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698 Jacob S. Hacker, *The Divided Welfare State: The Battle over Public and Private Social Benefits in the United States*. (Cambridge, UK: Cambridge University Press, 2002).

699 Mark Hall, "Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment." *University of Pennsylvania Law Review* 137, no. 2 (December 1, 1988): 431.

medicine."[700] By the early 1990s the hated word "rationing" became shorthand for the fear that any attempts to curtail medical spending would hurt patient care.[701] This became particularly associated with public and professional backlash against the role of physician as gatekeeper in HMO and managed care organizations.[702] Thus, as the literature began to associate rising healthcare costs with physician behavior, the conversation shifted to financial incentives and other external factors. Among these was the push for "pay for performance," an approach that gave monetary rewards for physicians for reaching certain targets with their patients, and which many have critiqued as too blunt and actuarial to have a real impact.[703] More recently however, the conversation has shifted from interested parties drawing a sharp dichotomy between patient wellbeing and cost control, to a more global focus on waste. Wasteful care, bioethicist and physician Howard Brody has argued, not only drives up costs, but can also be inappropriate and even dangerous to patients. Citing studies of relative patient outcomes in high-cost and low cost areas within the US, Brody argues: "nearly one third of health care costs could be saved without depriving any patient of beneficial care."[704] As Atul Gawande argues in a controversial 2011 article comparing McAllen, Texas, which at the time was the region of the US with the highest Medicare spending, to Rochester, Minnesota, one of the lowest, the role of physician practice culture can make a crucial difference. Such

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700 Edmund D. Pellegrino,"Medical Morality and Medical Economics." *Hastings Center Report* 8, no. 4 (August 1, 1978): 8.

701 James Morone, "Bias of American Politics: Rationing Health Care in a Weak State." *University of Pennsylvania Law Review* 140, no. 5 (May 1, 1992): 1923.

702 Daniel P. Sulmasy, "Physicians, Cost Control, and Ethics." *Annals of Internal Medicine* 116, no. 11 (June 1, 1992): 920.

703 Lois Snyder, Richard L. Neubauer, and American College of Physicians Ethics, Professionalism and Human Rights Committee. "Pay-for-Performance Principles That Promote Patient-Centered Care: An Ethics Manifesto." *Annals of Internal Medicine* 147, no. 11 (December 4, 2007): 792.

704 Brody, Howard. "Medicine's Ethical Responsibility for Health Care Reform — The Top Five List." *New England Journal of Medicine* 362, no. 4 (January 28, 2010): 284.

observations point to why externally imposed curbs on physician driven "overutilization" have had little effect, particularly when physicians are powerfully socialized, beginning in their residency training, into these habits of practice.[705]

IMGs, most of whom come to practice in the US as residents, experience the process of adjusting to US training—learning everything from new drug names, to American social mores, to managing hospitalized patients, often all at once and at a very fast pace. Alok Khorana's reminiscences of his first days as a resident, newly relocated from India to upstate New York, discussed in chapter 1, describe aspects of this initial adjustment process. Khorana calls for better structured orientation programs for IMGs, describing the current system as haphazard, stressful for clinicians, and potentially detrimental to patients.[706] Clinical educators have called for more research on "the facilitation of… acculturation into American society at large and the American medical environment in particular" for IMGs. As Gerald Whelan of the ECFMG, the credentialing body for IMGs in the US, presents the goals of this project, "acculturation" is something to be encouraged and streamlined. IMGs should learn to practice as American doctors. One of the examples Whelan cites, for example, is the field of behavioral health. In Whelan's view, because many IMGs come from cultures where "depression is seen as a normal part of life and not a condition for medical attention," IMGs need special instruction to make sure they appropriately medicalize this phenomenon.[707] Meghani and Rajput refer to acculturation as "practice socialization." In their words, "the wide range

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[705] Gawande, Atul. "The Cost Conundrum." *The New Yorker*, June 1, 2009. http://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum.

[706] Khorana, Alok A. "Disorientation." *Health Affairs (Project Hope)* 27, no. 4 (August 2008): 1154–59. 1155.

[707] Whelan, Gerald P. "Commentary: Coming to America: The Integration of International Medical Graduates into the American Medical Culture." *Academic Medicine: Journal of the Association of American Medical Colleges* 81, no. 2 (February 2006): 176–77.

of knowledge and practices from other countries, cultures, and healthcare systems" that IMGs bring to their US training creates a problem that needs to be solved in order to "help IMGs provide better care."[708]

Some of these medical educators are IMGs themselves, and their calls for better orientation of new residents are based in the practical needs of residents, the institutions they work in, and patients at large. As medical educator Kathleen Cole-Kelley puts it, however, the major challenge of this process is "recognizing the vulnerability of the IMG, without being either paternalistic or patronizing…"[709] The uncritical context of some of these approaches to "acculturation" reinscribe the neocolonial undertones of globalizing medical education. Many of these studies engage in some broad essentializations of medical education throughout the world. For example, one group of medical educators writing in 1990 described "foreign medical schools" as having "less comprehensive" clerkships, an "unrelievedly didactic" teaching style, and rigid "hierarchical relationships between teacher and student."[710] The implication is that foreign training is by some logic all the same and by definition inferior. When it is acknowledged, the diversity of IMG perspectives is seen as a liability rather than an asset. This discourse forecloses the possibility that IMGs may have skills or perspectives of value to bring their US training. Several of my interviewees, for example, commented on the fact that they felt they were better trained in physical diagnosis than their American counterparts, were more clinically experienced, and had proven qualities such as tenacity.

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[708] Salimah H. Meghani, and Vijay Rajput. "Perspective: The Need for Practice Socialization of International Medical Graduates--an Exemplar from Pain Medicine." *Academic Medicine: Journal of the Association of American Medical Colleges* 86, no. 5 (May 2011): 572.

[709] Katherine Cole-Kelly "Cultures Engaging Cultures: International Medical Graduates Training in the United States." *Family Medicine* 26, no. 10 (December 1994): 624.

[710] M. D Bogdonoff, and J. J. Fins. "University Medical Center Participation in Residency Training Programs for Graduates of Foreign Medical Schools." *Annals of Internal Medicine* 114, no. 5 (March 1, 1991): 426.

As discussed below, in some cases, IMGs are recruited to American residency programs for these very assets, though this is rarely officially acknowledged. From the perspective of a qualitative researcher, if not a medical educator, IMG insights are intrinsically as well as instrumentally valuable—sometimes inspiring insightful critiques of US healthcare and American practice culture.

THE HIDDEN CURRICULUM OF AMERICAN RESIDENCY TRAINING: DEFENSIVE MEDICINE AND PRACTICE CULTURE

In the process of learning the practical aspects of US practice, however, IMGs, much as American trainees, learn underlying and sometimes uncomfortable lessons and values. Medical sociologist Fredrick Hafferty popularized the term "hidden curriculum" to describe this process of socialization among American medical students.[711] Typically applied to studies of medical education, in the context of this project this "hidden curriculum" seemed to be equally if not even more powerful in residency training—a period where future physicians actually learn how to make clinical decisions. The IMGs I spoke with, who first experienced the US system as residents, describe encounters with a hidden curriculum that fundamentally challenged their engagement with resources in healthcare. Several of my interviewees reflected on aspects of this process. In particular, they identified the ways in which they came to engage in what they had initially seen as shockingly wasteful behavior. It was clear from listening to many of my interviewees that they did not share what Katherine Montgomery described as the "carefully preserved fiscal innocence" of American medical trainees. As a Pakistani physician remarked, "I

[711] Frederic W. Hafferty, and Dana Levinson. "Moving Beyond Nostalgia and Motives: Towards a Complexity Science View of Medical professionalism.(Report)." *Perspectives in Biology and Medicine*, September 22, 2008: 602.

am not the only IMG that is astounded at the waste in this system." She offered a couple of examples:

> I mean the other day I in was the ED, I was admitting this patient… I got called at 2am and he had diabetes and they hadn't done a recent glucose level on him. 50 year old man…but he'd had a pregnancy test done. I mean, just this mass testing. There was a patient that came in yesterday with right upper quadrant pain, and the attending and the intern and the whole bloody world wanted to do an ultrasound of the right upper quadrant. Why? It can be done outpatient, it's going to cost a lot inpatient it isn't emergent,…no Murphy's sign, whatsoever. I mean there may have something there, just do basic LFTs if they are terribly elevated we'll do something about it. Just because on the off-chance that there might be this one case that might be positive and if it's positive the hospital's going to get sued...[712]

Esther L., the East-African physician quoted at the beginning of this chapter had some of her own examples of resource culture shock to offer. The careful attention to resources she brought in from her previous training proved to be a liability working in an American tertiary care hospital:

> … in fact many times I was asked *why didn't you order this, why didn't you order that?* I was not used to ordering all these tests, for every patient you admit you order a CBC and a BMP…It wasn't something I was used to doing, if I needed to order a CBC I was thinking *what is the CBC going help in the management of the patient?* … So I used to think hard and strong before I ordered tests just because my patients also couldn't afford it. So if I'm ordering a myriad of tests the patient always got stuck up with a bill that the hospital had to swallow and it was a problem…Where here I was getting dinged for not ordering them…[713]

Despite a supposed new awareness of cost effectiveness in healthcare at the policy level, on the level of physicians' actual training experiences, this consideration appeared to receive less reinforcement, if not outright contradiction. In the case of this physician, "getting dinged" for thinking about cost-effectiveness is an example of the hidden curriculum at work. Several of my interviewees observed the subtle and not so subtle ways these cultural undercurrents within American residency training promoted waste

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[712] Laila A. interview with author, November 2014.

[713] Esther L. interview with author, January 2015.

and the perverse use of resources. As the Pakistani physician quoted above observed, one element of this was a systematic lack of cost awareness by medical practitioners, something she felt was particular to American health professionals. Defensive medicine and the fear of lawsuits was a theme that came up with the majority of my interviewees, but was more prominent in my conversations with physicians who were most recently in training. As our conversations suggested, this discourse about medico-legal issues was one of the main ways this peculiar and perverse relationship to resources was perpetuated in American medical practice culture.

As the health policy literature has emphasized for a long time, the cost of lawsuits is not a direct cause of the overall price tag of American healthcare. As malpractice reform in 30 states has demonstrated, reducing some of the potential burden of litigation has at most a marginal impact on malpractice costs, or most importantly on physician practice culture.[714] Regardless of these facts, the fear of malpractice litigation continues to be very real among physicians as a group and has had a strong influence on the way physicians are trained. Although I did not specifically ask about it, the fact that several of my interviewees discussed defensive medicine at some length was telling in this regard. For some, this was because it felt like such a contrast with their previous views of physician roles. For many, though certainly not for all of my interviewees, the implications of an antagonistic relationship between doctor and patient was new and startling. In Ester L.'s words, practicing in Kenya, where as a general rule "the patients just put the doctor on a pedestal. They do what the doctors say, they don't complain, they don't ask questions." This felt very different than practicing in the US where she had the

[714] Ezekiel J. Emanuel, "Where Are the Health Care Cost Savings?" *JAMA: The Journal of the American Medical Association* 307, no. 1 (January 4, 2012): 39–40.

sense that the relationship became more adversarial with "a lawyer breathing down your neck."[715] As Laila A. comments, repeated reminders from upper level residents and attendings about the culture of malpractice had particularly deep resonance for IMGs because of its very unfamiliarity. Although none of my interviewees mentioned actually being sued, the overall culture of fear had a powerful impact on how they learned to practice. In Dr. A.'s words:

> …we do have a bigger, I wouldn't necessarily social conscience, but sort of a better understanding of practicing medicine with limited resources. Which I think is a completely foreign concept to US graduates. They cannot fathom practicing medicine that isn't defensive. And I think we lose it really, really fast though. I think by the end of residency we're *more conservative* than American graduates are. Because most of us, I think probably go through an experience or two where we didn't order a test and got yelled at for it and whatever else. And …that's going to scare you. I still get in to a lot of trouble…[716]

As Ester L. puts it, "the fear of being sued…changes you as a physician. You almost do things because you are covering yourself, not because it's the right thing for the patient right now."[717] This fear, credible or not, becomes a powerful force socializing IMGs into American styles of practice and dulling some of their potentially useful perspectives on resource awareness. In the day to day world of residency, these physicians are not clued into the larger policy conversations about healthcare spending, physician practice choices and waste. Instead they are subject to a hidden curriculum through which sometimes directly contradictory messages are imparted to American-educated and international trainees alike. Thus the culture of defensive medicine adds a sense of irony to the experiences of some IMGs who came to the US to practice medicine the way they "wanted to." Although resource limitations no longer constrains what they could do for

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[715] Esther L. interview with author, January 2015.

[716] Laila A. Interview with author, November, 2015.

[717] Esther L. interview with author, January 2015.

patients, resource abundance compels them to over-test and over-treat, practices which they know could also be detrimental for patients and at for the healthcare system overall. As Mateo N., a physician from Mexico summarized his impression of the situation:

> The other things in the US system that are from my standpoint hard are politics, lawyers…now it's hard to practice good quality of medicine because of that …because a patient comes with chest pain to the ER. Maybe it can just be a chest wall inflammatory process, but you need to do the full work-up to rule out any coronary artery disease. So instead of paying $500 for an ER visit you end up paying $30,000 for a normal cardiac workup. And just to be sure that I did the right workup, just to be sure with the highest percentage that this patient is safe to go home. And for me, that's what the lawyers have done. For me you turn on the TV and then you see "oh, don't take Xarelto, if you have any bleeding, please call us, we can sue the doctor."[718]

For Dr. N., the logic of American malpractice culture has proved powerful. And it is all the more powerful because it was unexpected and unfamiliar from his prior training. He finds reinforcement for the concerns he has learned in his daily experience, for example, watching TV and seeing frequent commercials from malpractice litigators. He also feels, however, that the defensive medicine that he has learned is not the "good quality" care he had hoped to give to patients. Faris T., who studied medicine and practiced in Jordan puts the point somewhat more emphatically:

> I shouldn't criticize the system but I will…I think the way medicine is practiced here in the US is all defensive medicine. Like you're doing more just because you're afraid, you're not doing appropriate things. You have guidelines and you have the knowledge, and you're a physician, and you went to med school, and you went to residency, you shouldn't be doing stupid stuff, but why are you doing it? *Because I'm afraid I'm going to be sued.* And this is very inappropriate...[719]

In large part, the value of these perspectives lies in the fact that these physicians have experienced at least one other culture of medical practice. Two physicians I spoke with, Esther L. from Kenya, and Wei Z. from China, offered a more complex perspective,

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[718] Mateo N. interview with author, July 2014.

[719] Faris T. interview with author, January, 2015.

comparing one experience with the other. Dr. Z., describing how Chinese medicine had changed since he immigrated to the US in the 1980s, fears that it has become too unregulated.

> They don't have very strict things over there. One big thing I think they have problems with right now is that when I go back to China I see my friends, they fly all over the country to do surgery…I think that's the problem. The medical training is also maybe driven by money rather than the patient's quality of life. Like some people say the doctors have a black heart... those kinds of things I think are there, but they aren't everywhere…[720]

In Esther L.'s perspective, American physicians are overall "more careful."[721] This was not to say that she did not work with careful and competent physicians in Kenya, but that in a setting of huge work pressures and little accountability, these qualities were physician-dependent and could vary greatly. As Dr. L.'s other comments indicate, however, she feels that whether or not a culture of defensive medicine promotes this carefulness, it has its own unintended consequences for quality of care and for resource awareness on the part of doctors.

ACCESS TO CARE: DEPRIVATION AMID PLENTY

The physicians I spoke with came from a great variety of healthcare systems, as Wei Z.'s comments above indicate, some of these systems could be perceived to be even more marketized or commercialized than that of the US. Several, however, came from systems where universal access to care or healthcare as a human right was an ideal if not a reality. For physicians from these backgrounds, the waste of the US healthcare system was even more baffling. Some found it unsettling to watch patients in need go without in

[720] Wei Z. interview with author, January 2015.
[721] Esther L. interview with author, January 2015.

a setting where so many others are receiving unnecessary treatment. In the words of Sofia S., a gynecologist from El Salvador:

> One of the things is the health care system here. If you don't have insurance *oh well*…Back home we don't have that, we have a public system, like the Canadians. So even though we don't have huge resources, we don't have the latest technology or the latest treatments available, we still treat everybody. Everybody that comes to the public hospitals gets treated and we are not running the funding…I mean that was one of the biggest shocks I think, because back home … if she needs to be operated we're going to operate on her, but we're going to operate on people that really need it. Not like in this country, we have insurance, you don't need to have surgery you will have it. So that's still one of the many things that makes me upset. Because I see people that they have insurance and even though they don't need to have a hysterectomy, but they have a couple cramps per month they will have a hysterectomy, and then there are patients dying from endometrial cancer which is still in the early stages that I know we can cure them and if they don't have insurance, we cannot operate on them.[722]

Laila A. from Pakistan was also surprised by how difficult she would find this aspect of the US healthcare system:

> Like for us, it meant to be universal, it's a right, it's not a privilege. It's not like that in this country and I didn't realize how difficult I would find that. Universal healthcare is not considered a priority, universal car insurance is, but not universal healthcare, which is astounding to me... but I mean, honestly speaking, I didn't realize how all of that would sort of dissatisfy me in ways that it hasn't had before.[723]

In her case, concerns once again crystalized on wastefulness of the healthcare system. Her biggest frustration as a primary care physician was dysfunctional and wasteful way the US system handled both pain and addiction. She felt most emotionally torn after clinical encounters with patients she though were seeking narcotics to feed an addiction rather than to treat pain:

> Yes I am sympathetic to a lot of my patients who are in that position because I genuinely consider addiction a disease, but … especially when you come from an environment where you were fighting to get antibiotics for completely

[722] Sofia S. interview with author, February 2015.

[723] Laila A. interview with author, November 2014.

> preventable disease and then you're plummeted into this place where you're trying not to become someone's personal drug dealer, you know, it's a struggle…[724]

In a system where she felt structurally limited in her ability to actually treat addiction and address it as a mental illness and a social situation she was most frustrated by the adversarial relationship she felt it created with patients. The sheer amount of time and emotional energy spent acting as a gatekeeper for scheduled substances, was itself a waste of resources. In her perception, "mental health is largely and vastly ignored in this country… and just dealing with it by, by shoveling Norco down people's mouths" was a glaring flaw of the system.[725]

Adnan R., born in Canada to immigrant parents (themselves IMGs) and trained in Hungary, also felt that the way the US healthcare system handled its vast resources created somewhat perverse and adversarial relationships. Although Dr. R. had other reasons for returning to practice in Canada after residency in the US, his perception of the healthcare systems was added incentive. As he puts it, in Canada "I like the healthcare system better…as a physician and as a patient." Although both systems have their frustrations, he appreciates not having to deal with insurance companies, which he feels are "the biggest difficulty in practicing what you want to practice, because you have to answer to insurance companies which doesn't really sound right because they don't actually have the patient's…the patients in mind…so you're kind of competing against them…"[726] In his perception, although Canada has a shortage of specialists and long waits for elective procedures, "in the US we are doing too many things…"

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[724] Laila A. interview with author, November 2015.
[725] Laila A. interview with author, November 2015.
[726] Adnan R. interview with author, July 2014.

WASTE AND HUMAN RESOURCES: IMGS REFLECT ON THEIR OWN ROLES

Because IMGs generally come in to the US system as residents, these alternate and potentially valuable views often get lost in the course of training. In the power dynamic of residencies, residents have defined roles as learners. Although programs and pedagogical approaches vary, in general, there is little legitimation of any concerns they may have about the lessons they are learning. This is evident in the literature on IMG acculturation, which poses IMG diversity and any challenges IMGs may have in adjusting to American practice styles as problems to be solved, rather than as legitimate critiques of the system. As several of my interviewees have observed, this may be to the overall detriment of diversity of perspectives and practice among US physicians. While some important strengths IMGs bring to their American training are devalued, others are acknowledged somewhat perversely. When asked about ways in which they might have more or less prepared for residency than the US graduates in their training programs, several of the physicians I interviewed mentioned clinical skills and physical diagnosis as something they felt more confident in. As Arjay N., trained in India in the 1960s, compared the entering skillset of his fellow Indian-trained physicians with that of the USMGs in his residency program:

> So we had a breadth of knowledge . . . we were much better in physical diagnostics…bedside . . . being able to come up with things. Which many US medical students didn't know how to do physical diagnosis-wise; they were not practiced… We had bedside clinics throughout our third and fourth and final years. We would go every day to the bedside and we had to demonstrate to the instructor or the instructor will show it to you… for example while you examine the heart how you listen for a murmur. We'd be able to tell you what is the best position to do that, when should you do it, and how you should demonstrate that.[727]

[727] Arjay N. interview with author, January 2015.

Laila A., who trained in Pakistan in the 2000s, felt that she learned these skills well because the stakes were so high. As she puts it, "yes I listen to the lungs, but before I used to listen carefully, because I knew that if I missed something this was it." Sophia S., a gynecologist who trained in El Salvador in the early 2000s connects her confidence in physical diagnostics with the resource limitations of the setting in which she trained:

> Back home, we don't have CT scans right and left. We don't have ultrasounds right and left, so when I was undergoing my residency training I found myself to be a bit more aggressive or comfortable with clinical skills to a point… and also … at that time I'd already completed my internship and my social year.[728]

As discussed in the previous chapter, it is these clinical strengths, which were essential in resource-limited settings that erode over the course of American training. In another example of the hidden curriculum at work, despite any lip service paid to the value of clinical education, in practice these skills are systematically devalued. The message of American training to US and internationally-trained physicians alike is that medical identity is defined by the ability to access and wield "advanced" technology.

Sofia S. also points to another relative strength of IMGs in US training programs. Although a few may be new graduates, a significant number are more clinically experienced than a typical US graduate just out of medical school. The majority of the physicians I interviewed described significant clinical experience before coming to train in the United States—many had begun or completed residencies and a few had worked as independent clinicians or as attendings in academic settings. As a Jordanian internist speculates, this is an advantage prized but not necessarily acknowledged by the American residency programs that regularly accept IMGs. Describing how multiple American

[728] Sofia S. interview with author, February, 2015.

residency programs sent representatives to his hospital to recruit residents in the 2000s, he speculates on the benefits of such a recruitment strategy:

> …they were just impressed with Jordanian candidates and they're like *ok! We have five guaranteed people who are top of their class. Their scores are extremely high. They are going to be beneficial for the program*. When you look at residents you look at them as not only residents, you know they can teach their peers most of the time. Especially if their peers know they are good, they will come to them. It's much easier for an intern to come to his peer intern and ask him *what do you think I should do?* Than going to his resident or going to his faculty and asking them. So this is all rewarding if you look at it like programs do. They have benefitted a lot from having residents who were in training before coming here. We had the chance to get residency here, but at the same time we contributed a lot for others here to train under us while we are getting our training.[729]

Like this internist, and like IMG physician-writers such as Abraham Vergehese and Alok Khorana, other physicians I interviewed had perceptions about their roles as IMGs in the US medical training and healthcare systems that highlighted challenges and inconsistencies in mainstream thinking about their strengths and weaknesses. When asked what he felt IMGs contribute to US healthcare, Arjay N., who trained in several urban hospitals when he came to the US in the 1970s, responded forcefully, "sheer numbers! I mean such a great segment of the population would have gone without healthcare…"[730] Answering the same question, Wei Z., who came to the US from China in the 1980s also emphasized this aspect, in his words, without IMGs, "UTMB would be closed, Harvard would be closed!"[731] As a pathologist, he was particularly aware of the role of IMGs in keeping afloat specialties that happen to be unpopular among US graduates. In several institutions in which he worked, for example, the majority of pathologists have been International graduates. As Sophia S., who came to the US from El Salvador a decade and a half later remarked, IMGs of her generation also filled

[729] Faris T. interview with author, January 2015.
[730] Arjay N. interview with author, January 2015.
[731] Wei Z. interview with author, January 2015.

important gaps. "One of the biggest impacts is that foreign medical grads go into primary care a lot, and sometimes go into primary care and go to underserved areas for many reasons… visa issues."[732] [733]

As Laila A. emphasizes, IMG roles, and the crucial gaps they fill often go unacknowledged by the American medical mainstream. In her perspective, IMGs offer "that diversity element, I don't think they quite understand how important that is."[734] As Adnan R. emphasizes, "I think the international experience that many have come with is an asset to the medical system because they have different points of view… There's a high rate of immigration to North America, in general we're immigration states," and a diverse physician population can take better care of diverse, shifting "different kinds of populations, that come and go to different countries."[735] Dr. S. offers a concrete example of this observation particularly salient to the experience of IMGs from Latin America. In her words, "we contribute a lot with the language. Like my practice has all the Spanish speaking patients that you can think of. They are looking in the Hispanic communities, they are looking for somebody who can really speak Spanish and they can come to the clinic and you know, have their appointment in Spanish."[736] These perspectives speak to an awareness that IMGs play such a crucial role because the US medical education system has largely failed to create its own diversity or critically engage with the roles of physicians in the US healthcare system. Faris T. feels that IMGs will continue to have a place in US medicine so long as this education system fails to "change some of the

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[732] Sofia S. interview with author, February 2015.

[733] As several studies have found, the J-1 visa program has in fact been instrumental in staffing rural areas and Federally Qualified Health Centers in certain areas see Brooks et. al., "The Rural Physician Workforce in Florida: A Survey of US- and Foreign-Born Primary Care Physicians," *The Journal of Rural Health,* 19, no. 4 (2003): 486.

[734] Laila A. interview with author, November 2014.

[735] Adnan R. interview with author, July 2014.

[736] Sofia S. interview with author, February 2015.

mentalities how they are teaching their medical students…it's true you are getting more medical schools, you are getting more medical graduates, but you are not getting more people going into these primary care specialties. You're getting less maybe."[737] Laila A. feels similarly, "the main problem isn't the foreign medical graduate question… the problem is that *you* don't have enough doctors in this country, you still don't. There aren't enough doctors per person *with the way that you want to deliver healthcare.*"[738]

Once again, these comments about the role of IMGs in the US healthcare system come back to the overarching theme of waste. To Adnan R., the North American healthcare systems he has worked in have a perverse relationship not only with material, but with human resources. As he observes, many IMGs, either American or Canadian citizens who seek training abroad, or IMGs who are immigrants or visitors from other countries, find the increasingly onerous process of breaking into the system to be insurmountable. As described in prior chapters, for several generations, a largely invisible group of immigrant physicians have come to the US and found themselves unable to reestablish themselves in their profession, and yet for various reasons unable to return home to practice. Additionally, many IMGs who come to the US with significant experience, find themselves in training situations where their background is not utilized. As Dr. R. puts it:

> There's a lot of intellectual waste… for people that are trained as physicians, that can adequately do the work, and are doing things that are below their education level, that's a waste. It's a waste for the system and it's a waste, honestly, for the individual. I think all across the board, like I said for patients that need physicians, for a system that needs physicians, and for the physicians themselves.[739]

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[737] Faris T. interview with author, January 2015.
[738] Laila A. interview with author, November 2015.
[739] Adnan R. interview with author, July 2014.

As Arjay N. and Laila A. comment, the US healthcare system has benefited from this situation, filling the systematic gaps in the medical education system with IMGs trained at the expense of their own countries. Rather than facing a substantive conversation about the need to train more physicians to fulfill "the way *you* want to deliver healthcare," the American medical establishment, "got it cheap, very, very cheap." Thus, as these physicians are well aware, IMGs play a crucial gap-filling role in the US healthcare system—both in terms of their labor, and in terms of allowing decision makers to avoid some critical questions about the values and sustainability of its practices.

Conversations with Global Health: Reverse Innovation?

Overall, this project has elicited perspectives from an incredibly diverse group of physicians, whose countries or origin, clinical specialties, ages, and experiences can seem so different as to be incomparable. It is not surprising, then, that individual views, values and struggles have varied greatly. What these clinicians do have in common is the experience of working as doctors in more than one set of political, economic, and cultural assemblages. Although there is both a classic and growing literature on the ways that these systems shape the educational formation of clinicians, these studies, summarized briefly in the last chapter, have tended to limit themselves to particular national contexts. As increasing medical migration has become a fact in the last few decades, however, there is value in adding the experiences of the transcultural physician to this base of knowledge and theory. This perspective not only sheds light on the persistent linkage between medical training and migration, but also valorizes the perspectives of these clinicians on the healthcare systems they are entering. These clinicians, in between worlds, may have oblique views not easily visible from the mainstream. In Kleinman's

words, it is from these positions on the margins that "we can find the space of critical engagement to scrutinize how certain cultural processes come to injure us all, constraining possibilities…" A common theme variously manifested in all of these narratives was the challenge of adjusting, not only to the availability of resources in American healthcare, but also to the peculiar ways in which they are utilized. Something many articulate as wastefulness. Questions of waste bring up questions of value, what resources are considered valuable, and what uses of them constitute a misuse or misappropriation. In paying closer attention to the adjustment process of this group of clinicians, it is possible to critique the system they are adjusting to, bringing insights into American medical practice culture and the hidden curriculum of residencies through which it is imparted though contested perceptions of what is valued and what is wasted.

As discussed in the previous chapter, many of these clinicians came to the United States in order to fulfill their definitions of becoming "better" doctors. Achieving this goal, however, often comes with a complex set of unexpected consequences. By the end of training, whether or not they consider themselves immigrants or visitors, may find that they have become American doctors. The processes of "acculturation" and "practice socialization" touted as insufficient by some medical educators work all too well. In the words of Karthik R., a family physician from India, one of the main qualities of a successful international physician is adaptability. He explains, "you know, there is a saying by Darwin, the one who becomes successful is not the one who is intelligent or is hardworking, but who is very adaptive…I really believe in that."[740] From Adnan R.'s perspective, adaptability, a quality that IMGs need to be successful is important to all

[740] Karthik R. interview with author, July 2014.

doctors, arguing that part of being a good doctor is that "you have to be adaptable to your environment and to your patients."[741]

Although there is great value in fostering this quality in physicians, and particularly in IMGs, there is also value in acknowledging their ulterior perspectives and experiences rather than simply treating them as a problem to be solved. Within the global health community, an emerging discourse may provide a space for this conversation. Coined by Rebecca Onie, Paul Farmer, and Heidi Behforouz, the concept of "reverse innovation" suggests looking to successful health promotion efforts in resource-limited settings for models that can help alleviate costs and gaps in care in the developed world. Physician and columnist Pauline Chen, exploring this idea in a 2012 New York Times article introduces the concept through a story about a colleague who went abroad. Having "cared for dozens of patients with abscesses and broken bones, tumors and arrow wounds, relying on nothing more than a single rickety X-ray machine, a handful of battered surgical instruments and the aid of one well-connected local nurse," this physician returns, wondering, "We could get so much done with so little over there…It's like we're not doing something right over here."[742] The idea that the healthcare systems and providers of the rich world have something to learn from those of poor nations is an oddly novel suggestion, yet given the colonial and neocolonial history of the globalization of biomedicine and medical education, this idea is indeed an important departure. As Onie, Framer and Behforouz argue, importing these models often requires "a broader conception of healthcare," one that acknowledges "that patients' nonmedical

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[741] Adnan R. interview with author, July 2014.

[742] Chen, Pauline W. "What We Can Learn From Third-World Health Care." *Well*. Accessed August 19, 2015. http://well.blogs.nytimes.com/2012/07/26/what-we-can-learn-from-third-world-health-care/.

needs—access to healthy food or heat in the winter, for example…often thrust themselves into the doctor's office."[743] This expansive perspective provides a basis for appreciating the views and practice styles that clinicians develop in resource limited settings. The greater caution and clinical judgement these clinicians learn to employ in ordering diagnostic tests, as well the degree of social awareness that can be inevitable in a setting where clinicians' lives are to some degree constrained by the same structural limitations as those of their patients, are lessons that can be of value in the development of clinicians. Often, these perspectives endorse a patient-centered ethic, albeit in a different ways than it is expressed in American medicine, where, as ethicists and philosophers have argued for decades, technological intervention has been conflated with care.[744]

The term "reverse innovation," however useful, is also fraught with conflicting meanings and can lend itself to overly simplistic narratives. Although its originators strive to validate models of healthcare that rely on redefining innovation as the structures for using technologies rather than these technologies themselves, their choice of term oddly undermines this goal. "Reverse" innovation itself implies a progress narrative- and that applying low tech solutions often pioneered in poor nations such as *promotoras* and "health coaches," to the United States is somehow a reversion to a prior place in that trajectory, rather than a potentially valid or even superior alternate model. As Chen's example suggests, another challenge of this perspective is the pitfalls of romanticizing

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[743] Rebecca Onie, Paul Farmer, and Heidi Behforouz. "Realigning Health with Care." *Stanford Social Innovation Review*, Summer 2012. http://ssir.org/articles/entry/realigning_health_with_care.

[744] Perhaps the most famous example of this perspective is Francis Peabody,'s 1927 speech, *The Care of the Patient*, where he discussed functional illnesses, and the fact that medical students had perhaps become so scientific as to overlook the suffering of patients they could not diagnose or treat with the technologies of their day. Many decades later, Eric Cassel argued that medicine did not attend to the whole personhood of a patient, often causing suffering by viewing the patient as primarily a body to be fixed. Edmund Pellegrino clarifies that the biomedical good of a patient is only one several goods the patient can maximize and that biomedical care is only one way of defining care for patients.

clinical work in resource-limited environments. Narratives like that of her colleague focus on the creativeness, tenacity, and dedication of clinicians who work under these circumstances. Physicians who cope with resource-limited settings may indeed learn valuable lessons and skills that they would not learn in rich-world environments. However, valorizing only this perspective, to the exclusion of maintaining a critical lens on the reasons that these resources are lacking in the first place, can mask underlying global structures of inequality. As the historical aspect of this project has demonstrated, resource-limited settings become and remain limited for broader reasons, whether those be corruption and poor management of healthcare systems, or inequitable structural adjustment programs mandated by international creditors on debtor nations. Despite the challenges of the term, however, the discussion of "reverse innovation" has done much to raise questions about what it means to provide good care of people's health. Much like policy discussions of wasteful care and cost control, ideas about reverse innovation are often limited to the scholarly community. On a practical level, although more academic spaces exist to acknowledge and learn from the perspectives of physicians re-training in the United States, the day to day curriculum, hidden and otherwise, of training, particularly in residency training continues to mold IMGs, for better or for worse into American physicians.

Conclusion: Rhetorics, Realities and Futures

Addressing the 50th anniversary conference of the Educational Commission for Foreign Medical graduates in 2006, Elias Zerhouni describes his experience traveling from his native Algeria to the United States to become a physician. Perhaps the greatest factor that takes Zerhouni's story outside the norm is that at the time he shared his experiences, he was serving as director of the National Institutes of Health. Nevertheless his story shares some themes in common with IMG stories from this dissertation and from other narrative sources. He describes obtaining used copies of *Harrison's Textbook of Medicine* and the *Sabiston Textbook of Surgery* from a brother traveling in Europe and boarding one of the first airplanes of his life to take the ECFMG exam in Paris. One of the first Algerians to pass the exam, he traveled to the US for a short research assistantship in radiology through a personal connection between the dean of his medical school and a professor at Johns Hopkins University. Supporting his family by moonlighting in an Emergency room, he eventually began residency several years later, relocating his career when his wife, also an FMG, began her residency. As he observes, his path was somewhat atypical as "In those days, foreign medical graduates were not often offered this kind of opportunity."[745]

Zerhouni's story echoes many of the themes highlighted by the IMGs of a variety of ages and backgrounds who spoke with me during the course of this project. Like so many others, he did not begin his journey with the clear intention to immigrate, but rather "to get some experience learning cutting-edge radiology." Told through arhetoric of hard work and perseverance in the face of adversity, Zerhouni's early career is marked by vulnerability and uncertainty. Coming to the United States in the 1970s, a particularly

[745] Zerhouni, Elias A. "International Medical Graduates in the United States: A View from an ECFMG Certificant." *Academic Medicine: Journal of the Association of American Medical Colleges* 81, no. 12 Suppl (December 2006): S40–42.

controversial time for IMGs in US medicine, he struggled with language, with family responsibilities, and with the process of securing a residency in the specialty he had left home to pursue. He does not specifically analyze the factors that led him to stay in the US, however, as he mentions, radiology was not a strong specialty in his home country, and the chances of him making use of his Hopkins training there were probably uncertain at best.

In telling his story, Zerhouni is keenly attuned to his audience of American medical academics, charged with decision-making about the future roles of IMGs in the United States. He concludes his talk by calling for a greater internationalism in medicine and science, arguing that "we very much need young people from abroad in our universities," and that "our appetite" for scientific and medical talent, "is greater than our supply."[746]

Zerhouni's is perhaps the ultimate IMG success story, but is nevertheless marked by the factors that many of my interviewees found challenging about the IMG experience in the US and reflects longstanding tensions between the American medical establishment and the international clinicians that have been crucial to its success and survival. In the first chapter of this dissertation, I survey the available stories about the experience of migrant clinicians, drawing from memoirs, fiction and non-fiction writing, popular news accounts, and film to sketch out some of the ways IMGs see their own experience, and are perceived by the mainstream. Just as Zerhouni validates sharing his story as an alternative perspective on the IMG issue, I argue that reading these available stories is an important introduction to my approach to IMG experiences as embodying Arthur Kleinman's concept of experiences written at the margins. These perspectives, he argues are valuable for many reasons, but have particular power to reassess and question the common sense of the mainstream. This first chapter also serves as an introduction to the role of rhetorical images of international physicians in the United States and other

[746] Zerhouni, S41.

developed countries, something I examine more deeply for their constitutive role in giving meanings to IMGs in the US.

As Zerhouni's hints at in his talk, the receptivity toward IMGs in American medical institutions has been in flux throughout his career. As I examine in more depth in chapters two, three, and four, the rhetroics about international physicians among American medical academics and other decision-makers have varied throughout the years, but have tended to swing between extremes. During eras of uncertainty and change for American medicine, these migrant clinicians become more visible. When these periods also coincide with national debates on immigration, an often intensely negative rhetoric, painting this group as a threat or at the very least a problem has emerged. This rhetoric legitimates restrictive measures against this group, both at the policy level and at the level of individual attitudes among American residency directors and other academic physicians.

During more prosperous, less uncertain times, the interest in these doctors tends to fade, though internationally-trained clinicians remain a steady presence in American medicine. Thus Zerhouni's story is also unusual because of its visibility, a fact he himself seems to be well aware of. As I contend in this dissertation, the alternation of these periods of vituperative restriction and quiet permissiveness have cultivated IMGs as a vulnerable, flexible, and available workforce. In this way, international clinicians have been the consummate "gap-fillers" of the American medical un-system. As several scholars have recognized, IMGs continue to fill roles less popular among American-educated physicians, such as small town and inner city practices, as well as keep afloat needed but periodically unpopular specialties such as psychiatry, pathology, and at one point even anesthesiology. As I argue, the gaps they willingly and often ably fill, however, are not just simple deficiencies of labor to be staffed by "warm bodies in white coats," but are ideological and ethical as well. Having a ready and flexible supply of medical talent from abroad has allowed a tacit policy of undertraining clinicians for US

needs. The effects of this undersupply are most keenly felt in the so called "safety net" of the US healthcare system that serves poor, incarcerated, rural, and otherwise needy Americans.

Likewise, the steady supply of physicians from abroad has allowed American medical educators to avoid seriously grappling with questions of how to shape American clinicians to choose specialties that are perceived as less glamourous or remunerative. The flexibility and vulnerability of this group of physicians has also allowed this establishment to cling to often self-serving, and flawed ideologies, embodied in the Flexner report, about restricting medical training in the US to a small number of a particular type of student.

As Zerhouni expresses, even as an ambitious young Algerian medical student who had rarely traveled away from home, training in the United States had particular meanings for him and those around him. The second half of this dissertation examines these meanings and the contexts which bring them about. Contested ideologies seemingly removed from the technical world of medicine and biomedical science, such as turn of the century visions of capitalism, ideologies of racial and cultural superiority, and Cold War, and later neoliberal visions of development have in fact become so deeply embedded in the shape of medical education and delivery worldwide as to become matter of fact. As I argue, 20th century development efforts, as channeled through medical education have been simultaneously frustratingly ineffective and wildly successful. Strategies promoting "world class" medical education in poor nations have often deeply disappointed in terms of improving health or access to care, yet they have often created respected institutions that have produced generations of globally competitive physicians and scientists. These physicians are not necessarily any more equipped to deal with the challenges of lack of infrastructure, political instability, and resource limitations than their Western-educated counterparts, and can find these factors frustrating to their ability

to practice a universalized, global definition of good medicine in their often resource-limited settings.

Like Zerhouni's speech, this dissertation seeks to make these quiet stories visible, and examine them for what they can tell us, not just about the IMG experience, but about the structures of American medical training, and what it means in local and global contexts. In the final two chapters of this project I connect the literary and historical threads I have explored to the personal experiences of a small group of Internationally-trained clinicians that I interviewed. In conversations about what seeking American medical training has meant for them, a concept I call "The American Medical Dream," has emerged out of the stories of International physicians of different ages and origins. For many of these physicians, migration and medicine have been deeply intertwined. The reasons physicians chose to uproot lives and careers to come to the United States are complex; their experiences once they have immigrated are more so. As some have expressed, becoming a part of American medicine is an opportunity to be at the forefront of the field, a way to work with technologies they have only read about in their textbooks. For others, however, migration was the only way to see themselves as "good" doctors; seeing the broken structures and resource limitations of their environments as barriers to providing the kind of care they should be giving to patients and feeling impotent to change them.

Like all versions of the American dream, however, the American medical dream is not always what it seems. Many of the clinicians I spoke with had not initially intended to permanently relocate to the United States. As they became more adjusted to practicing amid the "medical plenty" of that environment, however, return became an increasingly complex question. Although sometimes motivated to seek advanced training in order to bring knowledge and technologies back home, at the end of their trainings, International clinicians often face the same structural barriers that had initially motivated many of them to leave. As many learn, actually making use of their new skills is often dependent

on the availability of resources and technologies that are not accessible in their countries of origin. Among the infrastructures often conspicuously missing are paths to re-entering the hierarchies of their home healthcare system at levels commensurate with their training. Returning home, many find, is a move that takes more risk, faith, and courage than even the initial move to pursue US training.

Hand in hand with these realizations, many of my interlocutors offered critiques of the US healthcare system just as they expressed the challenges of the systems in which they were educated. This dissertation legitimizes these critiques in context. Like Zerhouni, few of my interviewees expressed regret at coming to the United States, though several found the experience to be bitter-sweet in multiple ways. Drawing from unique insider-outsider perspectives "at the margin," many of these physicians offered insightful critiques of US systems of healthcare and medical training, and found themselves on a spectrum of resisting and accepting the powerful socialization forces of American medical training. A recurring theme, for example, was the culture of resource use, with many of my interviewees recalling getting "dinged," for not ordering tests or treatments they saw as wasteful, and encountering tacit discouragement when relying on their physical exam skills for diagnosis and management. These insights, like many views from the margins provide a point of departure for a broader lens, analyzing American medical practice culture and the ways it is sustained through graduate medical training. Many of my interlocutors also saw their own roles in the US healthcare system as a locus of critique, pointing out the hypocrisy of anti-IMG rhetoric and expressing an understanding of the IMG/USMG divide as a tacit class system in US medicine. As many of them recognized, many residency programs they took part in were reliant on their services in various capacities.

Overall, taking a broad, historical, as well as narrative lens to the roles and experiences of IMGs in the US healthcare system reveals a perennial reemergence of particular controversies and questions. Now, in the second decade of the 21st century,

experts are predicting that opportunities for International clinicians in the United States are likely to contract. Similar predictions, however made by individuals no less "expert" in the field however, turned out to be untrue in the late 1970s, 1980s and 1990s. Rhetorics pushing for restrictions on IMGs often bring about policy interventions intended to make the process of entering US training programs more difficult for this group. Overall, these policies have had transient effects, contributing to the vulnerability and flexibility of international physicians who come to the US. Often within a matter of years, however, labor-hungry training programs, local legislators in needy areas, and resourceful IMGs overcome these new sets of barriers.

Scholarship in other "magnet" countries for international medical migrants such as the UK, Canada, and Australia has begun to come to terms with the legacies of inter-dependence between migrant clinicians and national healthcare systems. As Parvati Raghuram argues from the British context, current ontologies of International health workers partake of narrow notions of nation, care and obligation. The contribution of "postcolonial thinking" to this topic is "to highlight historical connections that mark medical labor markets and how the category 'medical worker' is precisely dependent on this transnationalism."[747] Thus, not only have "overseas-trained" clinicians played an essential role in shaping healthcare in Britain, but the British system has reciprocally played a major role in shaping the training, prospects, and possibilities of these clinicians. Focusing on the long historical relationship of the British NHS and South Asian physicians, she demonstrates that even before these clinicians arrive in Britain they have been educated in a British-influenced postcolonial structure. Likewise, they have been immersed in an intergenerational legacy of traveling abroad for practice and training opportunities. Thus the knowledge that there would be a demand for South Asian doctors in Britain shaped what it meant to train as a doctor in these countries.

[747] Parvati Raghuram, "Caring about 'brain Drain' Migration in a Postcolonial World." *Geoforum* 40, no. 1 (January 2009): 25.

As Raghuram argues, these insights have ethical implications for how rich countries cope with their obligations to these clinicians and to their countries of origin. She critiques the push, often motivated by recent concerns about "brain drain" emphasized by the growing global health movement, to simply find ways to restrict the migration of physicians from poor to rich countries. Simply framing the debate about health worker migration as a balance of interests between the right of individuals to migrate and the right of those left behind to receive healthcare ignores historical complexity and perhaps unduly simplifies the responsibilities of recipient nations for these circumstances.[748] Historical patterns of rich nations' dependence on healthcare workers form poorer places shape patterns of training, meanings of pursuing medical careers, and future possibilities for these clinicians. Simply preventing physicians from immigrating to other nations does nothing to overcome the structural barriers that prevent the populations of their countries from receiving equitable access to health and care. It also does nothing to ensure that physicians can serve their patients to their full potential. Particularly in the United States context, these realities to a large extent go unacknowledged. Perhaps more so than other rich nations, scholars, medical educators, and policymakers in the United States have rarely acknowledged the extent that the American healthcare system in its current guise is reinforced by a steady stream of international clinicians. Thus the American medical establishment owes an ethical debt both to the physicians whose presence allows it to continue to function, and the nations, populations, and regions they come from.

As Zerhouni concludes, broadening his message from medicine to biomedical science, future advancements in research and its translation into practice are dependent on increased international collaborations. Referring to the global scourges of "AIDS, Malaria, and Tuberculosis," he acknowledges the value of "local physicians and scientists, mainly in the developing world…playing a significant role in…devising

[748] Raghuram, 25.

locally and culturally acceptable" approaches to these diseases.[749] Although this project is somewhat critical of some of the assumptions articulated by the protean entity called the global health movement, I also feel that some visions of this movement have the potential for moving past the rhetorics that questions of physician migration have been embedded in for the greater part of this century. Rather than treat clinicians in poor nations as invisible, or paint them as unpatriotic citizens choosing personal goals over the well-being of their compatriots, a critical global health lens has the potential to encompass the contexts and challenges with which physicians in resource-strapped nations contend, as well as understand these challenges in the contexts of broader historical processes of power and inequalities. A global health that respects the knowledge and experience of local biomedical practitioners, seeing them as potential partners and leaders rather than as lesser participants or opponents to efforts to expands healthcare access, has the potential to make change in hundred-year old rhetoric.

[749] Zerhouni, S42

Appendix A: Interview Questions

This appendix contains selections of interview questions I drew from when interviewing participants for the qualitative chapters of this project. Interviews were semi-structured, and although on occasion I would have the opportunity to ask most of the questions below, more often than not I let my interviewees direct the flow and order of the conversation. This set of questions was included in my institutional review board protocol and were reviewed and approved as a part of the IRB process. I include these here as a reference for my own future work as well as for any other researchers that may find them useful in designing their projects:

Oral Histories of International Medical Graduate Experiences in the Houston/Galveston Area

Sample Interview Questions

INTRO:
Hello, I'd like to start by introducing myself—My name is Rimma Osipov and I'm an MD/PhD student at the Institute for Medical Humanities at UTMB and this is my dissertation project— I really appreciate you taking the time to talk to me today and helping out with this process—I know you are busy! I want to write my dissertation about IMGs experiences in the US healthcare system and it's important to me to design a project that reflects the reality of that experience. I hope you can share your first-hand experience to help me make sure I'm asking questions—and drawing conclusions that are actually relevant!

Please let me know if you would be willing to do another follow up interview with me—this will probably take about an hour and can be organized around your schedule. If I use any quotes from our talks in my final project or publications, you will not be identified. We can take some time at the beginning of this interview to give you a pseudonym for the purposes of this dissertation.

Interview QUESTIONS:

1. Introductions:
    -Age;
    -Current place individual is practicing right now;
    -Location of medical school

2. What other countries have you practiced in as a physician?

3. Tell me the story of how you decided to become a doctor:

4. Tell me the story about how and when you decided to come to the US to be a doctor:
    -What factors were important in coming to the US?
    -What was the most important factors
    -What were some contributing ones
    -When did you first start considering this path, and why?

5. Did you change specialties when you came to the US?

6. What was the most challenging part of the immigration process?
    -Professionally?
    -Personally?

7. Tell me a little bit more about your time as a resident:
    -What kind of hospital were you at?
    -What was your patient population like?
    -Were your fellow trainees also IMGs or were they American trained? Some mixture of both?

8. What was the most challenging aspect of residency for you?

9. If you did a residency in another country as well, how does the US residency experience compare?

10. Overall, do you think you had a good training experience?

11. In your perception, do IMGs end up in different types of specialties than US medical grads? Why do you think that is?

12. Do you feel your background as an IMG has affected your career opportunities AFTER residency? Why?

13. What in your view is the most untrue stereotype about IMGs in American medicine?

14. Briefly, describe the contrast, if any, that you perceive in how your international and your American medical education dealt with the doctor-patient relationship? Are the expectations of how doctors and patients are supposed to relate different in the US than in other medical systems you have worked in or are familiar with?

15. Describe a good physician in the country you came from or where you went to medical school—now describe a good physician in the US… what are the major similarities and differences?

16. Do you think the patients you see in the US are different than the ones you encountered in your early training abroad? How so?

17. When you were studying medicine in your home country was healthcare considered a right, was it something available only to some? How do you see this contrast or compare with your experience in the US?

18. What was the role of primary care in your education abroad? Was it something that was taught and encouraged? How about preventive care? If not, what else was emphasized? What is different in your training here?

19. In you experience so far, what are some of the most challenging aspects of working in the US healthcare system? (Bureaucracy, insurance, patient attitudes, physician attitudes etc.)

20. In your experience, what were the most challenging aspects of working in the healthcare system in your country of training (or in other countries you have worked)?

21. Do your future plans include practice or other professional activity in your country of origin or training (for example, practice, volunteering, teaching etc.)? If not is this something you considered?

- What factors did you think about when you made this decision?
- What are the barriers to this kind of involvement
- What are some factors that may make it easier

22. What in your view is the most important positive impact that IMGs have had on American medicine?

23. What is the most important way that IMGs have enhanced the moral and/or professional tone and content of American medical practice?

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Rimma Osipov (Rimma Alexandrovna Osipova) was born in Novosibirsk, Russia to Raisa and Alexander Osipov on January 15, 1985. After immigrating to the United States with her family in 1989, Rimma grew up in Los Angeles, California and attended Palos Verdes Peninsula High School, graduating in 2002. From 2002-2006 She attended the University of California, Los Angeles (UCLA) and received a BA in history with a minor in anthropology. Before matriculating to the University of Texas Medical Branch (UTMB) she worked as a biological sciences technician with the National Oceanic and Atmospheric Association as well as a laboratory assistant at Century City Primary Care in Los Angeles. In 2008 she joined the UTMB MD/PhD program and formally began her work at the Institute for the Medical Humanities in January of 2011. During her time at UTMB she received generous support from the MD/PhD program, the Institute for the Medical Humanities and the McGovern Academy for Oslerian Medicine as a student Osler Scholar. Rimma has received numerous scholarships and awards including the William Bennett Bean Award, the David C. Eliand Scholarship in the medical humanities, and the Chester Burns award. Together with several students she received a President's Cabinet Award Grant to support Students Together for Service (STS), an organization dedicated to protecting and promoting the student service culture on campus. She has served as guest editor for the July 2011 issue of the AMA journal of ethics on the theme of physician writers. Rimma has participated as a facilitator and TA in multiple courses for premedical, medical and graduate students including the Joint Admissions Medical Program, the Humanities, Ethics, and Professionalism Course, and the Ethics of Scientific research course. She has also volunteered regularly at the St. Vincent's Student Run Free Clinic, where she served as student director from 2014-2015.

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