THE CARE OF FOREIGNERS: A HISTORY OF SOUTH ASIAN PHYSICIANS IN THE UNITED STATES, 1965-2016

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A DISSERTATION

in

History and Sociology of Science

Presented to the Faculties of the University of Pennsylvania

in

Partial Fulfillment of the Requirements for the

Degree of Doctor of Philosophy

2016

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To Baji, for whom words are insufficient

ACKNOWLEDGEMENTS

To Robby, Projit, Deb, and Keith:

Thank you for activating, challenging, supporting, and teaching me.

ABSTRACT

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This project explores the enduring consequences of postcolonial physician migration to the United States initiated during the Cold War. By examining local and global circuits of medical labor, I show how the intimate spaces of healthcare were influenced by liberal economic policies and ideological shifts to multiculturalism. Using oral histories, popular media, archival sources, and an ethnography of archiving, this project analyzes the ambiguous directionality of "care" attending to both the care provided by foreigners as well as the care extended to foreigners. Under the Hart-Celler Immigration and Nationality Act of 1965, the United States began to solicit the care of Foreign Medical Graduates (FMGs) largely from postcolonial Asian nations. FMGs were granted permanent residency or US citizenship in exchange for medical service in marginalized communities. Although this arrangement was conceived as a temporary solution, in the last fifty years, it has become a permanent fix with foreign physicians comprising a quarter of the physician labor force. This understudied contingent has become the numerical supplement built into the system, the global reserve labor force instrumentalized as a response to doctor shortages in inner city and rural communities. Their presence has deferred substantive structural improvements allowing organized

medicine and the state to maintain a two-tier system of healthcare delivery. Although the foreign physician was invited into the nation, the care provided by foreigners was received as different, an imperfect facsimile of their US counterparts. When care passed from the foreigner to the patient, there were confrontations because FMGs complicated normative constructs of physician expertise and authority. Over time, as familiarity with foreign physicians increased, the South Asian physician has notably disaggregated from the larger foreign physician group to emerge as a recognizable commodified cultural form. This is particularly significant today when the rhetorical threat of foreignness is used to incite terror. The South Asian physician is absolved from this homogenizing discourse as a result of the morality inhered in care work in addition to their socioeconomic position. This has mitigated their foreignness allowing a migration to the spaces of popular mass media where they are tolerated as fixed multicultural representations.

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INTRODUCTION: THE CARE OF FOREIGNERS

Introduction: The Care of Foreigners[1]

The British cantonment area in Pune, India left an impression. Navin Shah passed the military quarters on his way home, towing a bag full of soap scraps in hopes that he could sell these remnants for a few extra rupees. Profits from soap sales and tutoring supplemented the family income and contributed to his educational expenses. Shah was the son of a cloth salesperson always conscious of coming from a poor family. "That's the label we had," he remarked, "and I knew it and I felt it. Everybody knew that we were very poor and that's not a strong certificate to have in society." After independence, when the cantonment area was disbanded, Shah reveled in the celebrations. His "excitement and pride were infectious." He recalled, "In those days, every young man like me felt very proud being Indians because we were liberated…we felt good that the British rules had gone and that the struggles of the leaders gave results." Witnessing this momentous event in his formative years left a political residue on Shah that surfaced years later during his "fight for equality" in the United States.

[1] A note on terms: throughout the dissertation, I use "foreign" "foreigner," or "Foreign Medical Graduate" to refer to the first wave of migrants who came largely from Asia. In the early 1990s, as part of a political campaign, active FMG leaders decided to change their label to International Medical Graduates (IMG). Neither they, nor organized medicine used this phrase with any regularity until the late 1990s. In oral histories, all participants referred to themselves as foreigners or FMGs, which is why I used the term all the way through. Additionally, I use "foreign" as a way to differentiate between "foreign" –born FMGs and US- born FMGs who went abroad for medical school. US-born FMGs are excluded from this study for three reasons: they did not experience the same social and cultural barriers as foreign-born physicians, their education prior to medical school was in the US easing issues of documentation, and their numbers were very low until the late 1980s. This has changed in the last few decades.

However, the pride and excitement of independence had no effect on his "economic condition" or "schooling." With the help of a scholarship, he graduated secondary school in 1952 and set his sights on higher secondary, the equivalent of 11-12th grade in the US system. This was an expensive endeavor for a poor man, Shah explained, "but things worked out, it was destiny." While in higher secondary, he had the good fortune to befriend a "rich man's son," a member of the wealthy Indian business elite in East Africa. Because the educational possibilities in India were better than those in East Africa, families like that of his new friend sent their children back across the ocean for schooling. Pune was transformed into an "educational center." In 1955, because his wealthy friend spoke well of him, Shah secured a loan for 3000 rupees from his friend's father to assist with expenses while he attended medical school at the government subsidized institution in Pune. A few years after graduating, he built a surgery practice in Pune, a considerable accomplishment for a man of few means.

As he established himself as a surgeon, Shah committed to staying abreast of current medical knowledge. He made regular visits to the US Information Office to study "current" medical journals, which were at least a year old. One afternoon, a colleague dropped by his office unexpectedly to share news. The ECFMG exam was going to be offered in Bombay in three weeks time.[2] This exam was a doctor's " ticket to America," the friend explained. Agreeing to study together for the exam, the friends spent three weeks poring over textbooks and reviewing materials during lunch breaks and late into the evenings. On the day of the exam, they met early, purchased chai at the station, and

[2] ECFMG is an acronym for the Educational Council on Foreign Medical Graduates (Chapter 3). They are the institutional anchors for FMGs in the United States.

boarded the train to Bombay, a short journey that Shah remembered as filled with nervous energy. When the results arrived, only Shah had passed. He considered the new possibilities before him. With this "ticket to America" in hand, he left his wife, daughter, and a private practice to provide medical care in the postindustrial city of Akron, Ohio. Shah was invited to work as a medical intern in a small, underresourced community hospital. He joined a cohort of nine other foreign physicians, all from India or the Philippines.[3] The patients in the hospital were now under the care of foreigners.

The Care of Foreigners examines the ambiguous directionality of "care" attending to both the care provided by foreigners as well as the care extended to foreigners. The foreigner is invited "into the home that lets him enter after having appealed to him."[4] The United States began soliciting the care of foreigners during the Cold War, seeking their expertise to manage the health of marginalized communities. Between 1965-1975, approximately 75,000 foreign physicians entered the workforce under the Hart-Celler Immigration and Nationality Act of 1965, with Indians and Filipinos representing the largest percentages. As care passed from the foreigner to the patient, there were confrontations both because the practitioner was from elsewhere and also because their medical knowledge was acquired elsewhere. The care provided by the foreigner was marked as different, an imperfect facsimile of their US counterpart. Once the foreigner entered the nation, however, a tolerant care was extended to them based on the qualities and character of their professional location. In the present, Foreign Medical

[3] Navin Shah, interview by Eram Alam, Potomac, MD, June 14, 2014.
[4] Jacques Derrida and Anne Dufourmantelle, *Of Hospitality*, trans. Rachel Bowlby (California: Stanford University Press, 2000), 123.

Graduates (FMGs) continue to arrive, invited to fill vacancies in underserved hospitals. And like their predecessors from the Cold War period, the care extended to these foreigners continues to be a consequence of competing demands of national health and national security. Throughout the course of this fifty-year history, the South Asian physician has slowly disaggregated from the larger foreign physician group to emerge as a separate, recognizable cultural form.

By invoking Charles Rosenberg's *The Care of Strangers: the Rise of America's Hospital System,* this project extends his period of study into the present arguing that the strangers who provided care in the nineteenth and early twentieth century have morphed to include the figure of the foreigner today. The "strangeness" that Rosenberg identified was a result of the transition of care from something received in the familiarity of home by known individuals, to care administered in a sterile hospital by unknown nurses, physicians, and machines.[5] In this shift, the doctor and the patient became strangers to one another. Despite the distance, Rosenberg's stranger is located within the imagined community of the nation.[6] This was not the case for postcolonial Asian FMGs who immigrated as a consequence of the Hart-Celler Act. American social realities in conjunction with geopolitical anxieties motivated by anti-colonial movements, the threat

[5] Charles Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (New York: Basic Books, 1987).

[6] Benedict Anderson, *Imagined Communities: Reflections on the Origin and Spread of* Nationalism (New York: Verso, 2006). In the late nineteenth and early twentieth century, the Jewish doctor was also considered foreign. However, this perception changed as Jewish people "became white." Recent studies in Jewish history have explored the Jewish entanglement with racial categories in 20th c. America. See Karen Brodkin, *How Jews Became White Folk and What that Says About Race in America* (New Jersey: Rutgers University Press, 1998); Eric L. Goldstein, *The Price of Whiteness: Jews, Race, and American Identity* (Princeton: Princeton University Press, 2006); Matthew Frye Jacobson, *Whiteness of a Different Color: European Immigrants and the Alchemy of Race* (Cambridge, MA: Harvard University Press, 1998); and Eric J. Sundquist, *Strangers in the Land: Blacks, Jews, Post-Holocaust America* (Cambridge, MA: The Belknap Press of Harvard University Press, 2005).

of fascism, and the Cold War influenced the presence and experience of the foreigner who provided care. Although this caring foreigner was invited, they were located in an exterior position awaiting entry. Their crossing over the threshold of the nation produced a provocation with the proverbial host, a negotiation always in flux.

When foreign physicians were invited into the nation, their arrival was conditioned on the ability to provide care. Policymakers conceived of the citizenship-for-service arrangement as a stopgap mechanism, a temporary response to doctor shortages in inner city and rural communities across the country. However, in the last fifty years, this temporary solution has become a permanent fix with foreign physicians consistently comprising nearly a quarter of the physician labor force. Scholarship has largely neglected this constituency essential for the maintenance of a two-tier system of healthcare delivery in the American medical system.[7] This project attends to this omission to show how foreign physicians became the numerical supplement built into the system, the global reserve labor force instrumentalized as a response to the perpetual state of crisis. Their presence has effectively deferred substantive structural changes in the medical system that would ameliorate imbalances in access to care. However, to join the medical system, foreign physicians required proper documentation, a necessary bureaucratic practice to manage the immigrant.

In *The Care of Foreigners,* documents and the archive are a central concern, both in terms of content and form. Through bureaucratic mechanisms, global medical labor

[7] For an in-depth sociological study on Foreign Medical Graduates: Rosemary Stevens et al., *The Alien Doctors: Foreign Medical Graduates in American Hospitals* (New York: John Wiley and Sons; 1978).

was refined, reformatted and made transparent to the nation. The foreign physician was required to produce an archive of their expertise, a compilation of documents, which vouched for their medical knowledge and simultaneously formed the basis for their entry. In the stepwise production of this archive, a foreigner disclosed themselves losing their postcolonial obscurity to become documented immigrants. This project adds an anthropological analysis of this process to show how documentary subjectivity structured forms of knowledge as well as certain forms of self and memory for foreign physicians. In addition to the content of the archive, the proper form of the documents facilitated professional and personal possibilities. In the late 1980s, FMGs frustrated with discrimination often based on the form of their archive politically mobilized and demanded equal documentary requirements as their US colleagues. Their protest was met with limited success. Although the archive of expertise allowed the foreign physician entry into the United States, it also consolidated their foreignness by affixing them with the classificatory label *Foreign* Medical Graduate, orienting them always towards the outside. The document thus produced the foreigner.

FMGs originated from many nations. However, amidst this diversity of foreign practitioners, the South Asian physician has emerged as a representative form, a familiar brand consolidated and reproduced. The familiarity with this professional began in the intimate space of the clinical interaction, continued in the political realm as their class status increased, and was solidified in mainstream media. The invisibility of large occupational contingents in contrast to the notable presence of the South Asian physician is indicative of the class fissures in diaspora flattened by “model minority” subjectivities.

Scholars have long engaged in critique of this collapse providing important case studies, which re-interject history and political economy into the "model minority." This project applies this critique to the figure of the South Asian physician and expands the category even further arguing that the *kind of labor* in addition to class, must not be overlooked. The labor of the foreign physician carries with it the morality inhered in the social position of a physician. In this particular configuration, the South Asian physician is fixed and valorized, representationally elevated to the national realm and trusted to advise the health of the public. *The Care of Foreigners* captures and narrates the movements of the foreign physician through multiple physical and discursive sites including the bureaucratic, clinical, political and ending with the cultural. In this analysis, four major themes emerge to both conceptualize care and locate the foreigner.

The Crisis of Care

While the details of the introductory narrative are certainly unique, the broadly contoured routes were well traveled. No longer "coolie" laborers who surreptitiously escaped British merchant vessels in New Orleans, nor the Punjabi agricultural laborers in California and the Northwest, this elite migration of physician labor was welcomed to the United States to provide medical care in underserved countries across the country.[8] They were understood to be a solution to the doctor shortage "crisis" that threatened the health of the nation in the mid-twentieth century. This crisis, and those that would follow in the

[8] Vivek Bald, *Bengali Harlem and the Lost Histories of South Asian Americans* (Cambridge: Harvard University Press, 2015); Karen Leonard, *Making Ethnic Choices: California's Punjabi Mexican-Americans* (Philadelphia: Temple University Press, 1994). For more on early migrants see: Joan Jensen, *Passage from India: Asian Indian Immigrants in North America*, (New Haven: Yale University Press, 1988) and Rajani Kanta Das, *Hindustani Workers on the Pacific Coast, (Berlin: W. de Gruyter & Co, 1923).*

years to come, operated as a placeholder, a "primary enabling blind spot" such that ostensible solutions to the doctor shortage problem were deferred indeterminably.[9] Janet Roitman located the common etymology of crisis in the Hippocratic tradition where a crisis was a distinct moment that "called for a decisive action between alternatives."[10] In contemporary political discourse, crisis is recurrently mobilized thus losing its exacting momentousness. Instead, it has become an enduring state with an implicit sense of resignation to irresolution.

After 1965, a doctor shortage crisis mobilized thousand FMGs from postcolonial Asian nations to underserved communities all across the United States. However, this crisis and the subsequent welcoming of elite global labor was precipitated by decisions about the medical system previously put in place. In *The Care of Strangers* Charles Rosenberg documents the changes in healthcare, centering the hospital and arguing that it represented a microcosm of the changes occurring outside of its institutional confines. Rosenberg writes: "Within the walls of a single building, high technology, bureaucracy, and professionalism are juxtaposed with the most fundamental and unchanging of human experiences – birth, death, pain. It is no accident that both black comedy and soap opera should have found the hospital a natural setting. It is an institution clothed with almost mystical power, yet suffused with a relentless impersonality."[11] In these walls, the familiar contours of the physician emerged, an authoritative expert with a masculine

[9] Janet Roitman, "Crisis," in *Political Concepts: A Critical Lexicon*. Retrieved on July 30, 2016, from http://www.politicalconcepts.org/issue1/crisis/.
[10] Janet Roitman, "Crisis," in *Political Concepts: A Critical Lexicon*. Retrieved on July 30, 2016, from http://www.politicalconcepts.org/issue1/crisis/.
[11] Rosenberg, *The Care of Strangers*, 3-4.

demeanor, a professional with an orientation that ignored "the patient as social being and family member"[12] and prioritized scientific rationality.

By the twentieth century, the prestigious status of medical men was established and it was not unusual to "turn to [these] strangers for care at times of sickness."[13] Care by a stranger meant care in a hospital setting with strict procedural rationale, a therapeutic repertoire reinforced by a "legitimating aura of science"[14] and a faith in technological innovation and efficacy.[15] As Joel Howell explains, the increased usage of technology simultaneously increased costs associated with medical care, converting it into a luxury good accessible to elites.[16] This, in concert with the changes in bureaucratic management and efficiency explored by David Rosner in *A Once Charitable Enterprise,* resulted in a two-tier system of healthcare. One tier was technologically sophisticated and bureaucratically organized for the wealthy and the other that was idiosyncratic and disorganized frequented by poor, non-white or immigrant patients with few options due to prohibitive costs.[17] These changes, which produced a bifurcated system of care remains today. As Rosner describes: "The disorganization of the charity [hospital] system remains

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[12] Rosenberg, *The Care of Strangers*, 7.
[13] Rosenberg, *The Care of Strangers*, 8.
[14] Rosenberg, *The Care of Strangers*, 10.
[15] On the faith in the new bacteriology and public health and its impact on everyday life, see Nancy Tomes, *Gospel of Germs: Men, Women, and the Microbe in American Life* (Cambridge, MA: Harvard University Press, 1998) and Bert Hansen, *Picturing Medical Progress from Pasteur to Polio: A History of Mass Media Images and Popular Attitudes* (New Brunswick: Rutgers University Press, 2009). On the incorporation of medical science into clinics, laboratories, and medical schools, see: Harry Marks, *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900 – 1990* (Cambridge, UK: Cambridge University Press, 1997); Kenneth Ludmerer, *Time to Heal: American Medical Education from the Turn of the Century to the Era of Managed Care* (Oxford: Oxford University Press, 1999); and Barbara Barzansky and Norman Gevitz, eds. *Beyond Flexner: Medical Education in the Twentieth Century* (Westport: Greenwood Press, 1992).
[16] Joel Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: Johns Hopkins University Press, 1995.
[17] Rosenberg, *Care of Strangers*, 304.

today in the form of inaccessible and sometimes inappropriate facilities, often planned by those with private or provincial interests who pay little attention to gaps in the overall health system. At the same time, the modern hospital is often insensitive to the varied needs of the community."[18] The social divisions inhered in medical spaces were also reflected in the physicians who doctored at the various clinics, an institutional trend that relegated the marginalized to the care of foreigners.[19]

By the 1950s, technological advances facilitated the rise of medical specializations and a reduction in the family physician's presence and jurisdiction.[20] The decrease in family physicians and other general specialties resulted in short staffing and poor healthcare maintenance and management in under resourced communities. As the years went on, the chasm between high-cost specialized and preventative care accessible to wealthy patrons and essential basic services denied marginalized patients became a considerable obstacle.[21] Martin Luther King Jr. commented on this disparity, saying "of all forms of inequality, injustice in healthcare is the most shocking and inhumane."[22] Alondra Nelson shows in *Body and Soul,* segregated and subpar medical care was articulated as a central issue in the fight for justice waged by historically disadvantaged

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[18] David Rosner, *A Once Charitable Enterprise* (Princeton: Princeton University Press, 1986), 12. See also: Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1989).
[19] On the history of black physicians, see: Gretchen Long, *Doctoring Freedom: The Politics of African-American Medical Care in Slavery and Freedom* (Chapel Hill: University of North Carolina Press, 2016); Keith Wailoo, *Dying in the City of the Blues: Sickle Cell Anemia and the Politics of Race and Health* (North Carolina: University of North Carolina Press, 2001).
[20] Keith Wailoo, *Drawing Blood: Technology and Disease Identity in Twentieth Century America* (Baltimore: The Johns Hopkins University Press, 1999).

[21] Howell, *Technology in the Hospital;* Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1984).
[22] Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011), 5.

segments of the population in the mid-twentieth century.[23] Most notably, the Black Panther Party located health and the body as a fundamental site of struggle, recognizing the relationship between national sovereignty and bodily integrity as theorized by Michele Foucault in his concept of biopower. Demand for medical services also grew with the expansion of Medicare and Medicaid during this period. In the mid twentieth century, organized medicine and the government declared a doctor shortage crisis in response to increased demand for medical care and an inadequate supply of physicians.

The Care of Foreigners documents how foreign physicians served as a political and economic solution for this crisis of care repeatedly since the 1960s. Using the Hart-Celler Immigration and Nationality Act as a strategy to deal with the lack of sufficient manpower, Congress legislated the legal entry and eventual citizenship of elite Asian labor for the first time in 1965. In the first ten years after the passage of the Hart-Celler Act, FMGs emigrating from the Philippines, India, Pakistan, and Korea constituted the largest contingent, and at times comprised nearly forty percent of the physician labor force in the United States. FMGs completed their medical schooling and initial training in the sending country and arrived in the United States ready to work as interns and residents in underserved urban and rural areas. However, in the mid 1970s, physicians and politicians alike began to fear too many foreigners were diluting the prestige and

[23] Michael Byrd and Linda Clayton *An American Health Dilemma: Race, Medicine, and Health Care in the United States, 1900-2000* (New York: Routledge, 2000); John Hoberman, *Black and Blue: The Origins and Consequences of Medical Racism* (California: University of California, 2012); Jonathan Metzl, *The Protest Psychosis: How Schizophrenia Became a Black Disease* (New York: Beacon, 2011); Samuel Roberts, *Infectious Fear: Politics, Disease, and the Health Effects of Segregation* (North Carolina, University of North Carolina Press, 2009); Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (New York: Anchor, 2008). And for a study of a more recent case: Cathy Cohen, *Boundaries of Blackness: AIDS and the Breakdown of Black Politics* (Chicago: University of Chicago Press, 1999).

integrity of the medical profession, a position that was carefully manipulated by powerful forces such as the American Medical Association. The threat of the foreigner infiltrated the physical and psychic space of the medical profession. Congress responded by declaring the doctor shortage crisis was no longer at critical levels and immigration restrictions should be implemented to reduce the flow of FMGs. Although the doctor shortage situation had evidently resolved, the concept of crisis was recycled and invoked to describe the new state of affairs – by the 1980s, there was a potential crisis of oversupply. However, by the end of the decade, the AIDS crisis effectively muted the rhetorical oversupply and the care of foreigners was once again welcomed to assist in managing this mystifying epidemic.

In the years after the AIDS crisis, the supply of physicians and the subsequent legislative actions via immigration of Foreign Medical Graduates fluctuated in response to various geopolitical factors, such as the attack on the Twin Towers and internal changes to medical infrastructure. It was with the passage of the Affordable Care Act (ACA), that crisis found voice in its most recent iteration. Setting aside the political theatre catalyzed by this legislation, there was serious concern regarding the logistical implications of the bill. For the effective implementation of the ACA, specifically because of its focus on preventative and routine care, the United States required an increase in the number of primary care physicians to accommodate higher demand. Very quickly, Foreign Medical Graduates entered into manpower calculations and projections as an important source of immediate and inexpensive labor that could be marshaled with haste to alleviate the looming doctor shortage crisis. The crisis condition no longer

signaled a current situation, it was temporally flexible and defined an anticipated future event, a crisis yet to come.

This brief overview of how "crisis" has been invoked in response to medical manpower suggests that crisis has become the very condition of the system, an "ongoing state of affairs" where foreign physicians are added or subtracted to negotiate the condition.[24] Politically, the provocation of crisis is understood with a complementary call to deliberate action. However, if crisis has been elevated to the normal state of affairs, then how do we understand the norm and what exactly is the condition of crisis? Working in an African context, Janet Roitman and Achille Mbembe explain that crisis has become a condition that is "already there…thus one approaches the crisis not as system, but as a routinization of a register of improvisations…"[25] In the United States, care in these crises was conceptualized in terms of number of individuals qualified to provide it. It was a quantifiable variable. Foreign physician labor became a strategy to disregard structural inequities built into healthcare access by temporarily working in communities avoided by US medical graduates. FMG presence forestalled structural changes to healthcare delivery making them a successful long-term strategy to address the various crises of care.

The Place of the Foreigner

[24] Janet Roitman, "Crisis," in *Political Concepts: A Critical Lexicon*. Retrieved on July 30, 2016, from http://www.politicalconcepts.org/issue1/crisis/.
[25] Achille Mbembe and Janet Roitman, "Figures of the Subject in Times of Crisis," *Public Culture* 7 (1995): 326.

The phenomenon of foreign laborers participating in US markets in response to labor crisis is not unique. What makes the case studied in this project different is the combination of the kind of labor and the points of origin, namely elite South Asian physicians.[26] The professional qualities of these foreign expert combined with the logic of crisis meant these workers occupied a special position in both national policy and public perception in the second half of the 20th century. Although *The Care of Foreigners* begins in 1965 with the Hart-Celler Act, this legislative marker is in some ways arbitrary, a false start. In this project, the Hart-Celler Act is not understood as the singular defining moment in which foreign Asians were included in all aspects of the nation.[27] This project attends to Lisa Lowe's observation in *Immigrant Acts: On Asian American Cultural Politics*; "The 1965 Act has initiated not fewer but indeed more specifications and regulations for immigrants of Asian origin."[28] Lowe's perspective was confirmed in the late 1970s and early 1980s when there was a threat of physician oversupply and Congress instituted a Visa Qualifying Exam for physicians, the only test for US entry to date.[29] The groundwork for the 1965 physician migration was set in motion decades earlier, a consequence of various economic, political, and social occurrences both in the United States and South Asia. Vijay Prashad and Sujani Reddy argue against beginning Asian immigration histories with the 1965 Act false start because as Reddy explains, "[it] erases the role played by the U.S. nation state or U.S. based interests globally in fostering such

[26] Stephen S Mick, "Contradictory Policies for Foreign Medical Graduates," *Health Affairs* 6 (1987): 12.
[26] I use the term South Asian to include doctors from India, Pakistan, Bangladesh, and Nepal. Amongst this group, Indians comprised the largest numbers.
[27] On inclusion and citizenship, see Margaret Sommers, *Genealogies of Citizenship: Markets, Statelessness and the Right to have Rights* (London: Cambridge University Press, 2008).
[28] Lisa Lowe, *Immigrant Acts: On Asian American Cultural Politics* (Durham: Duke University Press, 1995), 9.
[29] Stephen S Mick, "Contradictory Policies for Foreign Medical Graduates," *Health Affairs* 6 (1987): 12.

flows [and] leaves no room for considering the participation of the United States in global histories of capitalist imperialism."[30] Additionally, by exclusively focusing on the legislative moment one risks the inadvertent slippage of equating legal citizenship with national belonging. To attend to these criticisms and concerns, it is necessary to locate the place of the foreign physician within a longer trajectory of Asian migration and labor.

In *Immigrant Acts,* Lowe examined the perpetual dislocation or placement of Asians on the outside arguing "Asia" has always been a "complex site on which the manifold anxieties of the United States have been figured."[31] As such, "the Asian is always seen as an immigrant, as the 'foreigner-within,' even when born in the United States and the descendent of generations before here born."[32] Asian laborers from countries including China, Japan, the Philippines, and to a much lesser degree, India, entered the United States in the nineteenth century establishing their lives as agricultural and construction laborers. As their numbers increased, politicians and business owners feared an oversupply of cheap labor, which would threaten the market and the homogeneity of the nation. To thwart this flow of foreigners, US Congress passed the Chinese Exclusion Act of 1882 prohibiting the entry of all Chinese laborers. As time went on the exclusions were extended to Asian Indians in 1917, Japanese immigrants in 1924, and Filipinos in 1934.[33] There was no place for the Asian foreigner in the nation.

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[30] Sujani Reddy, "The Hidden Hand': Remapping Indian Nurse Immigration to the United States," in *The Sun Never Sets: South Asian Migrants in an Age of U.S. Power,* eds. Vivek Bald, Miabi Chatterji, Sujani Reddy, and Manu Vimalassery, (New York City: New York University Press, 2013), 105.
[31] Lowe, *Immigrant Acts*, 4.
[32] Lowe, *Immigrant Acts*, 5-6. See also Sunaina Maira, *Missing: Youth, Citizenship, and Empire after 9/11,* (Durham: Duke University Press, 2009) and Mia Tuan, *Forever Foreigners or Honorary Whites? The Asian Ethnic Experience Today,* (New Jersey: Rutgers University Press, 1999).
[33] Lowe, *Immigrant Acts*, 13.

During and after World War II, due to shifting economic and political demands, the embargo on Asian labor was loosened slightly. With the 1965 passage of the Hart-Celler Act, particular forms of Asian labor that satisfied skill requirements constituted the first full wave of Asian legal migration to the United States. And thus began the migration of Asian foreign physicians to the United States, a trend that has resulted in a quarter of the physicians providing care in the United States over the last fifty years.

The imagined foreigner in much of Lowe's analysis, the object of "yellow peril," is an outsider originating in what would be called the "Far East." The South Asian migration to the United States have received less attention than the East Asian movements, most likely the result of the pervasiveness of the "yellow peril" discourse and fewer numbers of immigrants. Additionally, this may be because the South Asian or Indian assumed a different position in the global imagination extending from the time of British colonization to the present where India's economic prowess and cultural offerings are valorized and fetishized.[34] Recent scholarship has aimed to rectify this omission arguing that the understudied migration is revelatory of the subtle mechanics of empire and imperialism and has left traces both locally and globally in lasting ways that must be recovered. The collection of essays in *The Sun Never Sets: South Asian Migrants in an Age of U.S. Power* persuasively decenter the Hart-Celler Immigration and Nationality Act of 1965. Contributions by Nayan Shah, Seema Sohi, and Vivek Bald demonstrate the movement of South Asian immigrants in the late nineteenth and twentieth century into and out of both British and U.S. spheres of power "challenging their colonization as

[34] In this latest iteration, India, and not South Asia writ large, is the subject of praise.

British subjects and their racialization and criminalization by an anti-immigrant, anti-Asian, anti-radical U.S. state."[35] In their examples of interracial Punjabi-Mexican families, colonial British surveillance apparatus and operation in the United States, and Indian seamen who were "sojourners" in the United States with a regular presence in East Coast port cities, these scholars expose the limitations of a linear diaspora framework. They show how linear analysis can myopically privilege certain conceptions of "movement, settlement, and the attendant negotiations with power,"[36] while silencing others. They argue the place of the foreigner, similar to the idea of the nation, is a contingent location defined by variability and overlapping narratives rather than fixity of any kind. Although 1965 is still taken as the starting point of this project, this scholarship has influenced the theoretical periodization of *The Care of Foreigners* serving as a reminder that traces and remnants of histories past and projections of futures yet to come leave an indelible imprint on the present place of the foreigner. With this in mind, for South Asian physician labor, 1965 was indeed the historical starting point and foundational for their successive modes of incorporation in the nation in years to come.

Diasporas, belonging, citizenship, migration, labor – in the last decades, these concepts have routinely been subsumed and incorporated into the categories of globalization or multiculturalism, foregrounding economics as the motivating

[35] "Introduction," in *The Sun Never Sets: South Asian Migrants in an Age of U.S. Power,* eds. Vivek Bald, Miabi Chatterji, Sujani Reddy, and Manu Vimalassery, (New York City: New York University Press, 2013), 8-9.
[36] Introduction," in *The Sun Never Sets: South Asian Migrants in an Age of U.S. Power,* eds. Vivek Bald, Miabi Chatterji, Sujani Reddy, and Manu Vimalassery, (New York City: New York University Press, 2013), 7.

explanatory factor for all action.[37] In these versions of history, the place of the foreigner is reduced to the site of earning potential. While this certainly dictated some aspects of the entry of foreign physicians in the form of citizenship for medical service, the equation is incomplete. Aihwa Ong explains that in response to and in rejection of this globalizing discourse rooted in economic rationality, scholars have turned to "the local" rooted in local cultures.[38] This turn, Ong argues, reinforced a binary and "does not quite capture the horizontal and relational nature of the contemporary, economic, social, and cultural processes that stream across spaces. Nor does it express their embeddedness in differently configured regimes of power."[39] Jasbir Puar and Junaid Rana pursue these relational dynamics in their projects *Terrorist Assemblages* and *Terrifying Muslims* respectively, arguing that forms of South Asian/Muslim identity in the United States are understood and regulated via class, race, gender, and sexuality to produce contemporary subjects who are surveilled in numerous ways including the visual, the intimate, and the affective. Puar and Rana highlight the importance of class in the production and maintenance of difference and consumption as a central mode for ameliorating its effects. However, they show how class blurs into the intimate, reanimates the historical and rejuvenates the

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[37] This is theorized by Michel Foucault in *The Birth of Biopolitics* (Picador, 2010). For scholarship that disrupts these categories, see: Inderpal Grewal, *Transnational America: Feminisms, Diasporas,* Neoliberalism (Durham: Duke University Press, 2005), Chandra Mohanty, *Feminism Without Borders: Decolonizing Theory, Practicing Solidarity* (Durham: Duke University Press, 2003); Vijay Prashad, *The Karma of Brown Folk,* (Minneapolis: University of Minnesota Press, 2000); Deborah Thomas, *Exceptional Violence: Embodied Citizenship in Transnational America* (Durham, Duke University Press, 2011), *Globalization and Race*: *Transformation in the Cultural Production of Blackness,* ed. Kamari Clarke and Deborah Thomas (Durham: Duke University Press, 2006); Aihwa Ong, *Neoliberalism as Exceptions: Mutations in Citizenship and Sovereignty* ((Durham: Duke University Press, 2006); Anna Tsing, *Friction: An Ethnography of Global Connection* (Princeton: Princeton University Press, 2005).

[38] Aihwa Ong, *Flexible Citizenship: The Cultural Logics of Transnationality,* (Durham: Duke University Press, 1999), 4.

[39] Ong, *Flexible Citizenship*, 4.

sentimental in response to the War on Terror. Ultimately, they conclude that the place of the foreigner is tenuous, always teetering towards the outside of the imagined nation.[40]

These homogenizing narratives have terrifying effects. But despite their oppressive heft, the South Asian physician has managed to escape some aspects of this hegemonic rhetoric. This project argues that the moral valence of care combined with the professional prestige of physicians has softened this version of the foreigner. As professionals, they provided a needed service for the maintenance of population health. Because of this, the necessity of their work was understood differently, even from that of engineers and scientist who immigrated during the same period. As managers of "birth, death, and pain,"[41] intimate aspects of modern governmentality, the physician was seen to occupy a valuable social location with status and power. The foreign physician received the social benefits inhered in the physician's authoritative role, although not to its fullest social extent, which mitigated their foreignness. Additionally, the moral and religious undertones of care work moderated the Otherness of the foreign physician lessening the possibility they would be perceived as threat during a time when South Asians were largely seen as threatening. Instead, the South Asian physician has managed to migrate to the space of mass media, which Lisa Lowe has cited as a key cultural site "for the resolution of inequalities and stratifications that cannot be resolved on the political terrain of representative democracy."[42] Thus, the place of the foreigner is transformed into a

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[40] Jasbir Puar, *Terrorist Assemblages: Homonationalism in Queer Times,* (Durham: Duke University Press, 2007); Junaid Rana, *Terrifying Muslims: Race and Labor in the South Asian Diaspora*, (Durham: Duke University Press, 2011).
[41] Rosenberg, *Care of Strangers,* 2.
[42] Lowe, *Immigrant Acts,* 9.

representational form dislocated from its history and conditions of making and tolerated as an ideal type within liberal, multicultural imaginings.

The Documents of the Foreigner

To identify the foreigner, documents are essential. Within the document, the foreigner is made transparent and recognizable thereby reducing the threat of their foreignness. The un*document*ed immigrant without *papers* is contrasted with the immigrant who is able to perform a documentary disclosure in such a way so as to be recognized as a viable potential American. In the case of foreign physicians, professional identity was entangled with political identity, as one was the necessary condition for the other. As a result, reference letters, medical transcripts, certificates, exams, and licenses were the papers that allowed FMGs permission to enter and exist in the United States. This collection of documents -- the archive of their medical expertise -- was the bureaucratic regulatory mechanism that reformatted foreignness to make it compatible with US medical practice. In this procedural translation, FMG's medical knowledge acquired elsewhere and their knowledge of self underwent an epistemological revision. *Care of Foreigners* traces the emergence of this regulatory system, as well as the creative ways foreign physicians navigated and challenged the arbitrary and at times discriminatory logics of bureaucratic legitimacy.

The importance of bureaucracy and the document to govern difference has been researched most thoroughly in relation to colonial governmentality and the archive.[43] Ann Stoler writes in *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense*, the colonial archive is an attempt at producing "a grid of intelligibility fashioned from uncertain knowledge" because "uncertainties repeatedly unsettled the imperial conceit that all was in order, because papers classified people…and because colonial servants were schooled to assure that records were prepared, circulated, securely stored, and sometimes rendered to ash."[44] The document and the archive stabilized populations classifying people using rationality and organizational method. It was a technique to soothe the anxieties of colonial governments and ignore their lack of knowledge in places such as the Netherlands Indies or India. As a result, in the written document, governments located the legal presumption of truth. In *Government of Paper: The Materiality of Bureaucracy in Urban Pakistan,* Matthew Hull traces the continuities between British colonial and postcolonial inscription practices.[45] Hull shows how the bureaucratic apparatus that emerged as a management technology in the colonial regime and its obsession with documents has endured in the lives of contemporary South Asians. The material artifact is an enabling object, illuminating forms of sociality, foreclosing certain possibilities, and elevating the possessor of appropriate papers. Documents are

[43] For the importance of documents and documenting, see: Haimanti Roy, "Paper Rights: Emergence of Documentary Identities in Post-Colonial India, 1950-67," in *South Asia: Journal of South Asian Studies,* 39 (2016): 329-349; Ramah McKay, "Documentary Disorders: Managing Medical Multiplicity in Maputo, Mozambique." *American Ethnologist* 39(2012): 545-561.

[44] Ann Stoler, *Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense* (Princeton: Princeton University Press, 2010), 1.

[45] Matthew Hull, *Government of Paper: The Materiality of Bureaucracy in Urban Pakistan* (California, University of California Press, 2012). See also Akhil Gupta, *Red Tape: Bureaucracy, Structural Violence and Poverty in India*, (Durham: Duke University Press, 2012).

productive, embedded in lives and able to animate action, not simply objective, sterile objects impenetrable to the social.

The Cold War, the period during which foreign medical graduates began their migration to the United States, was a moment where concepts of "information" and "transparency" captured the political imagination of the powerful. Kregg Hetherington writes, "The failure of democracy and of markets in the Third World were both attributed to a lack of transparent information available to the citizenry."[46] In this new orientation, the document is central. Hetherington's project, *Guerilla Auditors: The Politics of Transparency in Neoliberal Paraguay*, documents the relationship between documentary disclosure and terror. If the documents were open, known, and legible, there was less to fear because the assumption was there is less to hide. The opaqueness of documents or the archive is what could lead to political upheaval or at worst a totalitarian regime.[47] This observation is echoed in Kirsten Weld's *Paper Cadavers*. Weld identifies two main archival logics: "the first logic was one of surveillance, social control, and ideological management, a Cold War-inflected logic that used archives as a weapon against enemies of the state. The second logic emerging from the records' rescue is one of democratic opening, historical memory, and the pursuit of justice."[48] These two logics were both operational in South Asian FMG's experiences; the first was foundational for inclusion

[46] Kregg Hetherington, *Guerilla Auditors: The Politics of Transparency in Neoliberal Paraguay* (Durham: Duke University Press, 2011), 4.
[47] Hetherington, *Guerilla Auditors, 42*.
[48] Kirsten Weld, *Paper Cadavers: The Archives of Dictatorship in Guatemala* (Durham: Duke University Press, 2014), 6.

and political possibility in the United States and the second mediated between versions of a postcolonial self and an American citizen fighting for equality.

Paper lives collapse difference, a necessary task when transforming a global medical labor force into physicians who can operate in the United States. FMGs' documents contain a promise to erase remnants of Third World doctoring, or at least reconfigure it, to align with US metrics, manners, and expectations. However, in this translation, vestiges of histories past, sentimental attachments, and forestalled futures remain. *The Care of Foreigners* explores these aspects of the document that exceed its claims to objectivity and mechanistic production. This project seeks to think through the forms that archives take and follows their operations in various arenas including official archives, personal papers, and mass cultural representations. In drawing together these varied archives, this project takes seriously Projit Mukharji's assertion that, "We cannot distinguish between the official archive and the vernacular archive on the registers of truth and falsehood, but must hope to do so at the level of different orders of information constituted within distinct textual economies."[49] Here, the vernacular is taken to encompass those forms not contained within the "official." Combining all of these documentary traces, a picture emerges of a particular South Asian physician whose inclusion is largely premised on proper documentation.

the intimacies of care

[49] Projit Bihari Mukhariji, *Nationalizing the Body: The Medical Market, Print and Daktari Medicine* (London, New York: Anthem Press, 2009), 28.

Rosenberg identifies "birth, death, pain" as the subject matter of the doctor patient relationship. These intimate events, the most "fundamental and unchanging human experiences," are the situations that implore care.[50] The doctor patient interaction requires both an intimate bodily disclosure witnessed on the limbs and organs, and an intimate internal disclosure of anxieties and discomfort experienced by the patient. When a familiar physician no longer delivered care, the strangeness of this encounter had to be negotiated. And when a foreign physician was the stranger delivering care, there were further complications. FMGs' corporeal difference from the normative white, male physician in addition to medical knowledge acquired outside of the United States meant they had to deliver care differently than their US counterparts to establish authority and expertise in the clinical encounter. Denied access to the performative scripts of their US based colleagues, FMGs modified language, comportment, and techniques of doctoring. While it is possible to argue that all physicians have to adjust in the clinical space, this project documents how racialized and gendered expectations were projected onto the South Asian physician. These expectations reflect a longer postcolonial legacy imprinted on the physician's foreign body. The cultural status and authority of the doctor in the United States did not subsume or erase FMG's foreignness.

In the late 19th and early 20th century, during the period of Rosenberg's *The Care of Strangers,* the medical profession was ascendant in American society. New technological innovations, surgical procedures, and medical discoveries led to public

[50] Rosenberg, *Care of Strangers, 3*.

confidence in these predominantly medical men.[51] As biomedical knowledge increased and became specialized, the informational asymmetry between the average patient and their unfamiliar physician grew markedly. In the post-war period, optimism regarding the power of new pharmaceutical products such as antibiotics only served to accentuate public enthusiasm regarding the potential of the biomedical future.[52] Irrespective of this distance, physician still had to deliver care and patients had to temporarily suspend their discomfort to receive care. Trust in physician's institutional role meant that patients were willing to make themselves vulnerable when receiving intimate care.[53] As Paul Starr chronicles in *The Social Transformation of American Medicine,* the rising cultural authority of the physician had the effect of lessening the power of the patient. This imbalance could silence the patient in a paternalistic matter, sidelining them in their care and dismissing their intimate knowledge of self.[54] The negotiation of these dynamics becomes most apparent in moments of uncertainty. In *Making Sense of Illness,* Robert Aronowitz explores the anxiety in various clinical case studies demonstrating how the social is negotiated to define disease. In this process, omission, elisions, and reductions are necessary to concretize biomedical categories. In Aronowitz's examples, tensions

[51] For more on those who were excluded, see Chapter 3.
[52] New scientific approaches to the investigation and use of pharmaceuticals brought widespread enthusiasm. For the classic history of the rise of the randomized controlled clinical trial, see Harry Marks *The Progress of Experiment*. On the role of pharmaceutical industry and the increasing prevalence of pharmaceutical products in daily life in the United States, see Jeremy Green *Prescribing by Numbers*. Bert Hansen describes representations of heroic physicians from the end of the 19th through the middle of the 20th century as represented in diverse sources of popular culture in Picturing Medical Progress. The post-war period through the 1960s has largely been seen as a "Golden Age of Medicine" for the U.S. physician, despite the fact that some classic studies have shown the effects of laboratory medicine were much less influential in decreasing mortality that was commonly thought. See Thomas McKewon *The Role of Medicine*.
[53] Erving Goffman, *Interaction Ritual: Essays in Face-to-Face Behavior* (New Brunswick: Transaction Publishers, 2005, orig. 1967).
[54] Jay Katz, *The Silent World of Doctor and Patient* (Baltimore: The Johns Hopkins University Press, 2002; orig. 1984).

around trust between the doctor and the patient are significant. And when a foreign physician is providing care, uncertainty is amplified.[55] Questions of cultural competency, linguistic ability and embodiment become a part of the clinical interaction in ways that are different from the experience of US physicians and their patients.

One of the most publicly recognized examples of misplaced trust is the Tuskegee Syphilis Study. The infamous observational research program, which began in 1932 as a low cost study of the natural course of untreated syphilis in African American men, came to stand for abuse of medical authority in the United States in the last decades of the 20th century. Susan Reverby in *Examining Tuskegee* references the power asymmetry as one of the most salient aspects of collective memory of the study; "doctors using their trusting subjects and federal state, and local health authorities abusing their power."[56] When the study was exposed in the 1970s, it bolstered proponents of informed consent who feared the possible abuses that physician trust and status could perpetrate. Ethicist Jay Katz advocated for informed consent such that the physician patient interaction transformed into a "dialogue and mutual decision making" rather than a unidirectional monologue. Promoting informed consent is an implicit (and sometimes explicit) recognition of the dangers of social hierarchies and the abuses this could engender in the intimate spaces of care. Frantz Fanon in *Black Skin, White Masks* also attends to the central role of language and speech in the production of subjectivity. He argues that language is an index of social location and linguistic mastery is a perceptible outward culmination of a cultural life

[55] Robert Aronowitz, *Making Sense of Illness: Science, Socity, and Disease* (Cambridge: Cambridge University Press, 1999).
[56] Susan Reverby, *Examining Tuskegee: The Infamous Syphilis Study and Its Legacy* (Chapel Hill: The University of North Carolina Press, 2009), 4.

world.[57] Within the clinical encounter, performativity of status and expertise through technical language is an essential component for establishing trust between doctors and patients. In addition, the physician must be adept to the cultural world invoked by the speech of the patient. As this project shows, foreign physicians were able to master the technical aspects of medical language, but were not initially acclimated to patient's vernacular cultural worlds. Organized medicine repeatedly questioned this cultural gap in relation to FMG's doctoring capabilities, citing it as a marker of their inadequacy and a deterrent to the proper administration of intimate care.

Scholars have long documented the moral and political registers embedded in the intimate space of care, recognizing the regulation of bodies and intimacy as a colonial and neocolonial mode of governmentality.[58] Following Michel Foucault and Sander Gilman, Megan Vaughn explores the colonial construction of African identity through the realm of medical knowledge practice in *Curing Their Ills: Colonial Power and African Illness*.[59] In "States of Hygiene," Warwick Anderson writes, "the state is licensed to palpate, handle, bruise, test, and mobilize individuals, especially with those deemed,

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[57] Frantz Fanon, *Black Skin, White Masks (New York: Grove, reprinted 2008).*

[58] For neocolonial/imperial examples: Laura Briggs, *Race, Sex, Science, and U.S. Imperialism in Puerto Rico,* (California: University if California Press, 2002); Natalie Molina, *Fit to Be Citizens?: Public Health and Race in Los Angeles, 1879-1939,* (California: University if California Press, 2006); Elizabeth Povinelli, *Empire of Love: Toward a Theory of Intimacy, Genealogy, and Carnality,* (Durham: Duke University Press, 2006); Johanna Crane, *Scrambling for Africa: AIDS, Expertise, and the Rise of American Global Health Science,* (Ithaca: Cornell University Press, 2013).

[59] Michel Foucault, *History of Sexuality* (Vintage, 1978); *Madness and Reason: A History of Insanity in the Age of Reason* (Random House, 1965)*; The Birth of the Clinic: An Archaeology of Medical* Perception (Vintage, 1994). A selection of explicitly colonial contexts: Frantz Fanon, *A Dying Colonialism,* (New York: Grove, 1965); Sander Gilman *Difference and Pathology: Stereotypes of Sexuality, Race, and Madness* (Ithaca: Cornell University Press, 1985); Meghan Vaughn *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991); David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth Century India* (California: University of California Press, 1993), Mukharji, *Nationalizing the Body*.

dangerous, marginal, or needy."[60] In this tactile assessment of care, there is a discrete demarcation between those who are able to touch and those who are touched. In *Colonial Pathologies,* a case study of American colonization of the Philippines, Anderson identifies "white [male] American medicos"[61] as the individuals able to manipulate Filipino bodies in an effort to provide care and instill hygienic virtues. Catherine Choy also describes an example of a violent medical touch in the same context stating, "Filipino cholera victims physically resisted taking anticholera drugs, so that American doctors at times had to use force when administering their medicine."[62] Through their management and handling of Filipino bodies, these physicians hoped to conform aberrant Filipino bodies to a modern standard form. Bodily transgression through touch occurred in the direction of the colonizer to the colonized, from the white expert to the non-white "infantile, immature subject."[63] Intimate medical touch in this and other colonial examples generally follows this directionality, from those with power to those with less. *Care of Foreigners* adds nuance to this directionality by focusing on the intimate medical interactions between the post-colony and US healthcare disrupting the focus on US Empire abroad.

Attention to this movement of care from the "South" to the "North" has received attention in the context of nurse migration from India and the Philippines to the United

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[60] Warwick Anderson, "States of Hygiene: Race "Improvement" and Biomedical Citizenship in Australia and the Colonial Philippines," in *Haunted by Empire: Geographies of Intimacies in North American History* ed. Ann Stoler, (Durham: Duke University Press, 2006), 97.

[61] Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006), 9.
[62] Catherine Choy, *Empire of Car: Nursing and Migration in Filipino American History* (Durham: Duke University Press, 2003), 24.
[63] Anderson, *Colonial Pathologies*, 3.

States. Touch and intimate care are particularly salient in the context of nursing. Catherine Choy's *Empire of Care* and Sujani Reddy's *Nursing and Empire* are corollary projects to this study. Choy and Reddy explore the migration of Filipina and female Indian nurses to the United States respectively, in response to a "crisis" and shortage in nursing professionals during roughly the same time period. As was the case with FMGs, foreign nurses were placed in hospitals and clinics considered least desirable, the hospitals avoided by white nurses. Nursing was historically gendered, both before and following professionalization. It was understood to be a natural fit for women since nurturing and care work were attributes of a feminine disposition and professional nursing was though to be an extension of this inherent character. This perspective, which Susan Reverby traces for the United States in *Ordered to Care*, was exported in various ways through the Rockefeller Foundation in India and individuals such as Lavinia Dock in the Philippines, an activist in U.S. nursing and "the internationalization of professional nursing."[64] Because of normative gender frames that exist both culturally and professionally, the touch of the foreign nurse was not perceived as an intrusion of bodily integrity in the same way that a male, foreign physician was received.

These dynamics are essential for thinking through the role of the foreign physician in the intimate space of the clinical interaction. In other words, what happens when a foreign physician "is licensed to palpate, handle, bruise, test, and mobilize individuals"? These mostly male foreign practitioners began their medical careers in ways that mimicked Anderson's "white American medicos" on "those deemed

[64] Reverby, *Ordered to Care;* Reddy, "'The Hidden Hand'"; Choy, *Empire of Care*, 23.

dangerous, marginal, or needy." However, while reminiscent of the colonial medical encounter, this dynamic played out in US hospitals and clinics. FMGs were sent to inner city and rural communities to manipulate, interpret, and learn from bodies considered marginal. The foreigners cared for the medically neglected. The FMG's South Asian identity added an additional level of complexity to hierarchies regarding expertise, cultural capital, and racial identity in the early clinical encounters of their US based careers. Over time, however, the FMG acquired enough skills and expertise to relocate to communities where their medical care was better compensated. The foreigner physician was now providing care to patients that were often wealthy and white. In this transition, organized medicine was threatened by the foreigner and responded in ways that were disparaging both personally and professionally. Despite these protestations, the intimate touch of the foreigner was permitted to trespass and inspect the body of a white patient for diagnostic or therapeutic care purposes, thereby shifting power dynamics in this clinical encounter. In the form of this interaction, a foreign physicians transgression of the social order is tolerated and has become normalized because their care work is essential to the nation.

The Care of Foreigners: Structure and Outline

This project analyzes the history and experiences of the first wave of foreign physicians migrating from South Asia to the United States. To understand this migration and its effects, *The Care of Foreigners* draws on a diverse source base including Congressional Hearings, published medical, scientific and social scientific literature,

personal archive, oral histories[65], and popular cultural products. In combining these materials, this project provides a multi-sited and multi-scaled historical analysis of the foreign physician from the pages of documents to the realm of public culture. A notable omission in this history is that of the patient. However, the aim of the project was to center the experience of foreign physicians, a marginalized contingent in the medical care system, focusing on the nuances and texture of their subjective position as physicians and immigrants.[66] The chapters are organized chronologically and thematically beginning in 1965 and ending in the present.

Chapter 1, "Importing a Solution" analyzes the Hart-Celler Immigration and Nationality Act of 1965. During the Cold War, the United States experienced a dearth of expert scientific and medical labor. To compensate for this lack, the Hart-Celler Act facilitated the migration of elite laborers, allowing skilled immigrants from postcolonial Asian nations entry into the United States for the first time. The inclusion of these professionals served two important purposes: it supplemented the inadequate US labor supply and signaled to the world that the United States was an open, multicultural democracy. Foreign Medical Graduates were welcomed as an efficient and effective solution for doctor shortages and were sent to provide care in inner city and urban communities across the country. After the legislation passed, procedures had to be put in place to document and account for the influx of foreign medical labor.

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[65] Except for Navin Shah, the oral history participants chose to remain anonymous. Many explained they felt more comfortable this way since they are still in medical practice. They are represented with initials throughout the text.

[66] South Asian men dominated the initial migration. In later years, women foreign physicians began to increase in numbers, although still relatively small. Nevertheless, they are a group that deserves careful study.

Chapter 2, "Papering Over Difference" investigates the bureaucratic mechanisms and documentary procedures necessary to become a Foreign Medical Graduate in the United States. State and local bureaucracies were tasked with converting a global supply of medical labor into legible doctors for the American healthcare system. In this conversion, proper documents were essential. To achieve recognition in the United States, the paper presentation of self became an important practice for personal identity and professional possibility. In the Cold War era of transparency, documents had the power to verify or falsify a person. After successfully completing a documentary disclosure of themselves and their expertise, foreign physicians were permitted to enter the clinic. Chapter 3, "First Contact" uses the clinical space as a site to explore how foreign physicians complicate normative constructions of physician expertise, credibility and authority. Although FMGs occupied a privileged position due to their professional skills, strong discriminatory attitudes towards these physicians remained. In spite of these hardships, FMGs acquired clinical skills and knowledge that allowed them to leverage their training into various forms of economic and political capital. This was important during the "fight for equality."

Chapter 4, "Political Branding" narrates a political history of FMG mobilization and activism during the 1980s and early 1990s highlighting the efforts of Navin Shah, one important node in the network. Fed up with unequal treatment, foreign physicians organized into an Alliance of FMGs to persuade organized medicine and the US government to rid the system of discriminatory practices. South Asian physicians emerged as the most vocal contingent. In the course of the struggle, they became a

recognizable political "brand." Chapter 5, "Brand Placement" thinks through the construction of the "brand" to ask why South Asian physicians have a significant presence in the mainstream American imagination. This argument begins with the economic to suggest that geographic mobility was an important contributory factor for the accumulation of wealth and entry into the upper class. In addition, the qualities of physician labor and the trust necessary for medical care mediated the foreignness of the South Asian physician. This allowed a migration to the realm of public culture that was perceived as non-threatening.

CHAPTER 1: IMPORTING A SOLUTION

"Doctor Shortage is Called Acute," warned *The New York Times* in 1961.[67] The country had an insufficient number of physicians and the situation was worsening. Between 1959 and 1961, a study reported a 33% increase in the number of rural communities lacking adequate physician care. Inner city communities also experienced a similar dearth of personnel, which adversely affected population health.[68] In response to this crisis, in 1964 the US Department of Labor officially declared a doctor shortage and Congress was tasked with providing a legislative solution. Policymakers used the Hart-Celler Immigration and Nationality Act of 1965 as a vehicle to supplement the national supply of physician labor with a cadre of Foreign Medical Graduates (FMGs) originating largely from India and the Philippines who were able to provide medical services shortly upon arrival. The bill included a special preference category for "aliens seeking to enter the United States for the purposes of performing skilled labor… [when] there are not sufficient workers in the United States."[69] The legislation served two purposes – one concerned with rapidly increasing the domestic labor market and the other as a political signal that the United States, as a paragon of democracy, was inclusive and welcoming to foreigners.

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[67] Emanuel Perlmutter, "Doctor Shortage is Acute," *The New York Times,* October 3, 1961, http://query.nytimes.com/mem/archive/pdf?res=9E05E7DF143CEE32A25750C0A9669D946091D6CF.

[68] Richard Lyons, "Doctor Shortage Nearing a Crisis," *The New York Times,* September, 28, 1967, http://query.nytimes.com/mem/archive/pdf?res=980DE3DB1238E53BBC4051DFBF66838C679EDE.

[69] Immigration and Nationality Act of 1965

Congress convened special hearings to investigate the particulars of the doctor shortage crisis in the United States aiming to locate the causes. The foremost conclusion was the stagnant supply of US educated physicians was unable to accommodate the increased demand, which was caused by aging and demographic changes, the expansion of Medicare and Medicaid insurance, and the "guild-like" restrictions imposed by the American Medical Association (AMA). Congress responded to the problem with the use of immigration legislation to welcome skilled migrants. Between 1965 and 1975, over 75,000 foreign physicians arrived to staff inner city and rural hospitals across the country. FMGs completed their medical studies in the country of origin and worked mostly as interns and residents in the United States. In exchange for their medical service, foreign doctors received permanent resident status or US citizenship.

The 1965 Immigration Act marked a symbolic shift from the previous Immigration and Nationality Act of 1924. The 1924 policy was restrictive and discriminatory with its use of an immigration quota system and the barring of Asian immigration. These closed, isolationist policies ran counter to US Cold War political and economic objectives and required remediation. As the global superpower to emerge after WWII, it was incumbent upon the United States to operationalize new ideals of global, social and economic integration. The first large scale global migration of elite medical labor was oriented with attention to these principles. It was a policy response inflected with global and national insecurities prevalent in the mid twentieth century. On a geopolitical level, Nazi totalitarianism and Soviet communism haunted Western liberal democracies with their meteoric rise. "It burst upon mankind unexpected and

unannounced"[70] and blindsided the international community to such a degree that preventing the future possibility of these totalizing regimes became an all-consuming effort. Scholars and politicians frequently suggested diversity, pluralism, and later multiculturalism as a way to thwart the rise of any monolithic ideology within nations. Multiculturalism elevated the humanist liberal claim to recognize the inherent value of the individual and applied the Enlightenment ideal to cultural groups. Thus, in order for a cultural democracy to properly function, it was necessary to publically acknowledge and value different cultural groups. However, these ideals were enacted in ways that were, and continue to be, highly unsystematic and contentious.

In this chapter, I investigate this medical service for citizenship arrangement that facilitated the migration of physician to the United States focusing on the Hart-Celler legislation as the narrative anchor. The chapter begins with an exploration of the doctor shortage on a domestic level, paying attention to the reduced supply and increased demand that fueled notions of a crisis in health manpower. These factors, ranging from demography to civil health rights activism, came together in the mid twentieth century to elevate doctor shortage to the level of urgent crisis in need of attention. Next, the chapter pivots to the geopolitical scale arguing physician migration was a political necessity during the Cold War as a way for the United States to showcase the benefits of democracy, reaffirm a commitment to free market capitalism, and bolster its supply of

[70] Carl Friedrich, "The Problem of Totalitarianism – An Introduction" in *Totalitarianism; Proceedings of a Conference Held at the American Academy of Arts and Sciences*, (Cambridge: Harvard University Press, 1954), 1.

scientific and medical labor.[71] Analyzing physician migration with attention to local *and* global demands deprovincializes the problem of US doctor shortage to show how liberal economic policies and ideological shifts to multiculturalism and diversity influence the intimate spaces of healthcare delivery in the United States. Integrating the two scales explains why a doctor from Hyderabad, India was the family physician to rural farmers in Tuscaloosa, Alabama or why a physician trained in Lahore, Pakistan operated at Cook County in inner city Chicago. This initial migration catalyzed by the Hart-Celler Act was the first of many to come and essential for acclimating US publics to the care of foreigners.

Doctor Shortage?

On September 28, 1967, *The New York Times* reported, "Doctor Shortage Nearing A Crisis." The "need for physicians placed at 50,000" and "many areas left with none."[72] Legislators were galvanized by the idea of crisis and set out to ameliorate doctor shortages with urgency. As investigation into the problem began, policy makers were confronted with the actual complexity in the seemingly simply concept of shortage. Was there a shortage in manpower in terms of bodies or physician work hours or medical specialties? Or was shortage simply an issue of geographic maldistribution? To assist with the investigation of the problem, the Department of Health, Education, and Welfare

[71] This connection has been well documented in regards to physics and other basic science research during the Cold War. See: Paul Forman, "Behind Quantum Electronics: National Security as Basis for Physician Research in the United States, 1940-1960," *Historical Studies in the Physical Sciences* 18 (1987): 149-229; Gabrielle Hecht, "Introduction" in *Entangled Geographies: Empire and Technopolitics in the Global Cold War* (Massachusetts: MIT Press, 2011); Allan Needell, *Science, Cold War and the American State: Lloyd V. Berkner and the Balance of Professional Ideals* (Amsterdam: Harwood Academic Press, 2000; Jessica Wang, "Science, Security, and the Cold War: The Case of E. U. Condon." *Isis* 83(1992): 238-269.
[72] "Doctor Shortage Nearing a Crisis," *The New York Times,* September 28, 1967.

commissioned a study by economist Rashi Fein to provide an "economic diagnosis" of the shortage. Fein argued that policymakers drew a false equivalency between the need for physicians and the need for physicians' services.[73] If need for services was the metric used, the number of physician hours necessary to perform a task or treat an illness should be the unit of measurement. Technological advancements, patient demographics, and disease load could be considered in this model of doctor shortage, allowing for a more targeted approach to the problem. Fein's policy recommendation using this understanding was to reorganize the current physician workforce. He concluded that implementing group medical practices and increasing auxiliary medical personnel such as nurses and physicians assistants was the best approach to alleviate the medical shortage.[74] Fein was against a simplistic understanding of shortage as an issue that could be resolved with more physician labor.

Opponents of this policy proposal, most notably from the American Medical Association (AMA), criticized the recommendation arguing that the number of physician hours could never be assessed thoroughly or effectively. Instead, the AMA endorsed the more common understanding of doctor shortage based on physician to population ratio, a calculation that ignored geographic variability and medical specialty distribution amongst other variables. The simplicity of this calculation not only made it an attractive and operational strategy, it also reinforced the primacy of the physician's role at a time when auxiliary health professionals were beginning to enter the healthcare marketplace. In the early 1960s, despite the glosses and shortcomings in the physician to population ratio, the

[73] Rashi Fein, *The Doctor Shortage: An Economic Diagnosis* (Washington D.C.: The Brookings Institute, 1967), 6.
[74] Fein, *The Doctor Shortage*, 90-130.

AMA convinced the US government to use this metric as the basis for future action ignoring the reluctance of some policy officials. Abraham Ribicoff, Secretary of Health, Education, and Welfare explained his hesitation: "I am deeply concerned at trying to write in a pattern of action now, anticipating what might take place 10 years from now, and find 10 years from now what we have provided is no longer the problem."[75] Nevertheless, he too succumbed to the physician to population ratio calculation as the way to understand doctor shortage. Ribicoff implored Congress to establish long term strategies to prevent future crisis by providing training and construction grants intended to increase the number of medical schools, hire faculty to teach at these schools, and improve the quality of programs that trained medical professionals.[76] He saw these measures as necessary actions to address the reduced supply and increased demand for medical services. Without these changes, the crisis would continue into perpetuity.

Reduced Supply

The doctor shortage, which culminated in the first migration of postcolonial foreign physicians, was years in the making. During the first half of the twentieth century, the number of medical school graduates slowly declined. Policymakers identified two important reasons for the attenuation: " (1) the limited enrollment capacity

[75] U.S. Congress, House, Committee on Interstate and Foreign Commerce, *Training of Physicians, Dentists, and Professional Public Health Personnel: Hearing before the Committee on Interstate and Foreign Commerce*, 87th Cong., 2nd sess., 1962, 91.
[76] U.S. Congress, House, Committee on Interstate and Foreign Commerce, *Training of Physicians, Dentists, and Professional Public Health Personnel: Hearing before the Committee on Interstate and Foreign Commerce*, 87th Cong., 2nd sess., 1962, 16.

of the schools; [and] (2) the mounting cost of professional education."[77] In addition,, historians Kenneth Ludmerer and David Rosner argue the effects of the Flexner Report (1910) and the AMA's efforts to consolidate the medical professions were two significant causal factors for the shortage by the mid-twentieth century. Education reformer Abraham Flexner was concerned with the inchoate nature of medical education in the United States. He criticized disparate medical school admission criteria and curricular planning, instead suggesting all medical students begin their education with basic science training as a way to standardize medical education. Flexner also stressed proper hospital training as an integral curricular requirement and proposed medical schools affiliate with a hospital to provide students with a clinical training site.[78] His recommendations were received as commandments and many medical schools sought to implement the changes to differentiate their medical program, marking it as scientifically rigorous. However, implementing these changes was an expensive endeavor and usually necessitated an expansion of medical school facilities. These additional expenses were transferred to students in the form of increased tuition, a prohibitive cost for many.

Flexner's recommendations closely mirrored the changes that the AMA's Council on Education advocated during this same period. The Council on Medical Education established metrics and standards for their new vision of medical education promoting full time medical school, higher tuition, and an increase in years of enrollment. Based on their criteria, the Council assessed and classified extant medical schools as acceptable or

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[77] U.S. Congress, House, Committee on Interstate and Foreign Commerce, *Training of Physicians, Dentists, and Professional Public Health Personnel: Hearing before the Committee on Interstate and Foreign Commerce*, 87th Cong., 2nd sess., 1962, 13.
[78] Rosner, A *Once Charitable Enterprise*, 64.

not and supplied state licensing boards with a list of AMA approved medical schools. AMA recommendations were taken with great weight and respect and state boards started granting licenses only to students who attended AMA approved schools. Through mechanisms such as this, the AMA established a stronghold over the direction of medical education and foreclosed enrollment for much of the population. This blurry system whereby privately decided upon AMA standards were translated into public, state policy continued into the post war years and affected FMG migration and licensing.[79]

Towards the middle of the twentieth century, the increasing cost of medical education was a barrier to much of the population and prevented enrollment in training programs. Dr. L.F. Kimball of the Rockefeller Institute lamented this issue in his opening remarks at a United Hospital Fund fundraiser in 1961. He explained:

> To become a properly qualified doctor today requires in most cases six to ten years of training – even more in some specialist fields – after graduation from college. These are years of very hard work for little or no income for that work. The youngster thinking of entering medicine must accept that fact that his parents or his wife will have to support him until he is almost 30 years old. Alternatively, he may have to go into heavy debt to meet his expenses.[80]

If the doctor shortage was to be curtailed, qualified persons, irrespective of financial background, should be encouraged to enter the profession. Student loans for medical education became an attractive route to entice a more diverse socioeconomic population. In 1959, Secretary Ribicoff explained, nearly half "of the medical school graduating class

[79] Starr, *The Social Transformation of American Medicine,* 118-119.
[80] Emanuel Perlmutter, "Doctor Shortage is Acute," *The New York Times,* October, 3, 1961, http://query.nytimes.com/mem/archive/pdf?res=9E05E7DF143CEE32A25750C0A9669D946091D6CF.

came from the 10 percent of the American families having incomes of over $10,000." [81] He presented this figure to show that a disproportionate number of medical school admissions occurred from the wealthy in American society. Ribicoff feared that the high cost of medical education was "a discouraging factor for the brighter young men with lower income families who are reluctant to assume a debt for medical school over their normal [college] debt,"[82] an observation which continues to hold today.

After mounting pressure from various parties to address this issue, Congress passed the Health Professional Assistance Act of 1963, one of the first pieces of legislation aimed to increase medical manpower. The act provided financial assistance in two areas: construction grants for medical institutions to expand their facilities and educational loans for medical students. Full time students entering medical school were eligible for government loans with a low interest rate and no security deposit. This provision was included with the intention to encourage enrollment of underrepresented students of low socioeconomic backgrounds who might not be able to provide a security deposit. Legislators hoped this would persuade these students to become family physicians and provide care in shortage area communities to improve the skewed geographical distribution of doctors. There was an addendum to the loan stipulation that included a 50% loan forgiveness program for physicians who practiced in rural and inner city communities. However, the powerful AMA lobby voiced its opposition to the

[81] U.S. Congress, House, Committee on Interstate and Foreign Commerce, *Training of Physicians, Dentists, and Professional Public Health Personnel: Hearing before the Committee on Interstate and Foreign Commerce*, 87th Cong., 2nd sess., 1962, 112.
[82] U.S. Congress, House, Committee on Interstate and Foreign Commerce, *Training of Physicians, Dentists, and Professional Public Health Personnel: Hearing before the Committee on Interstate and Foreign Commerce*, 87th Cong., 2nd sess., 1962, 92.

forgiveness program the day before the House vote and it was removed from the final version of the bill. This political theatre was in line with the AMA's vision of the medical profession - upper class, white, and male. The removal of the forgiveness program intensified shortages in underserved communities across the country, the primary work destination for foreign physicians.

While the Cold War ideologically fixated on science and medicine, historian Paul Starr noted that interest in scientific growth in the form of basic science research was not coupled with an effective strategy to handle the "deficiencies in the distribution of medical services."[83] The National Institutes of Health and the Centers for Disease Control received large infusions of federal capital, increasing budget sizes exponentially in the amorphous pursuit of scientific growth. However, an equivalent infusion of capital was not targeted for basic healthcare needs of Americans. Thus, the government's enthusiastic funding of basic science in addition to the AMA's political maneuverings to limit entry into the medical profession contributed to forestall necessary structural improvements to increase the physician labor force in the lead up to the crisis state of the mid-1960s.

The changes described above on the national level were incremental, slowly contributing to a physician shortage. However, this was not the case with the Vietnam War, which required an abrupt demand for physicians overseas and instituted a "doctor draft" until 1973. The government initiated the draft by amending the Selective Service Act of 1948 and required two years of active service by a physician in the Army, Navy,

[83] Starr, The *Social Transformation of American Medicine*, 337.

Air Force, or Public Health Service.[84] In an essay entitled "Draft Doctors: The Impact of the Vietnam War on the Migration of Foreign Doctors to Canada," David Wright et al., cite a Department of Defense report that stated, "80 percent of all male physicians in the United States under thirty-five had served in the Armed Forces or held reserve commissions."[85] This statistic included a combination of actually drafted doctors and those who were draft volunteers. While medical personnel was undoubtedly necessary overseas, many physicians never left the United States working at army bases and recruiting centers across the nation. Nevertheless, as drafted physicians, their medical services were no longer available to satisfy general public demand. In their stead arrived foreign physicians heavily originating from Asia. As one Pakistani doctor commented, "The Vietnam War was the greatest thing that happened to me. Those guys [US physicians] were going to Asia and we [FMGs] were coming from there."[86] This physician noted the ironic circularity of global physician movement – FMGs arrived in the United States to fill the vacuum created by Vietnam War draftees and provide care to fulfill the medical demands of the American public.

Increased Demand

In the 1950s, the Centers for Disease Control's Vital Statistics Report stated: "the combined effect of much higher birth rates and the continued reduction of the age-

[84] Melissa Klein, "The Legacy of the 'Yellow Berets': The Vietnam War, the Doctor Draft and the NIH Associate Training Program," (Bethesda: National Institutes of Health, 1998), https://history.nih.gov/research/downloads/YellowBerets.pdf
[85] David Wright et al., "Draft Doctors: The Impact of the Vietnam War on the Migration of Foreign Doctors to Canada," *Doctors Beyond Borders: The Transnational Migration of Physicians in the Twentieth* Century eds. Laurence Monnais and David Wright, (Toronto: University of Toronto Press, 2016), 170.
[86] Dr. TA, interview by Eram Alam, Westchester, New York, March 5, 2016.

specific death rates…increased the number of persons at the very young and very old ages."[87] These demographics were the highest users of medical services.[88] Medical advancements that reduced infant and early childhood mortality, a post World War II rise in birth rates and increased longevity of the elderly exerted a marked strain on an already stressed healthcare system. The demand for medical services continued to increase into the 1960s and 1970s. However, sluggish rates of medical school enrollment and graduation were unable to accommodate the rise in market needs of the population. In 1967, *The New York Times* reported, "the average numbers of persons cared for by each family physician has risen from 1300 in 1950 to 1700 in 1960. This figure is expected to rise to 2000 by 1970."[89] This misalignment, without swift decisive action in the short term, was bound to lead the healthcare economy from the precipice of an economic crisis into certain catastrophe. The current physician workforce could not absorb the demand. And to further exacerbate the problem, Lyndon Johnson passed the Social Security Amendments of 1965 as part of the Great Society initiative. Commonly referred to as Medicare and Medicaid, these programs expanded health coverage to the elderly and the indigent and were understood part of a larger civil rights agenda.

Four months prior to the passage of the Social Security Amendments, the Office of Equal Health Opportunity was established to develop a plan to address the amorphous

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[87] "Vital Statistics of the United States1950," U.S. Center for Disease Control and Prevention, http://www.cdc.gov/nchs/data/vsus/vsus_1950_1.pdf, 62.
[88] U.S. Census Bureau, "Historical National Population Estimates: July 1, 1900 to July, 1, 1999," http://www.census.gov/popest/data/national/totals/pre-1980/tables/popclockest.txt
[89] Richard Lyons, "Doctor Shortage Nearing a Crisis," *The New York Times,* September, 28, 1967, http://query.nytimes.com/mem/archive/pdf?res=980DE3DB1238E53BBC4051DFBF66838C679EDE

Title VI of the Civil Rights Act of 1964. Title VI mandated that federal funds must not support institutions that acted in discriminatory ways and the federal government was responsible for establishing and enforcing standards for nondiscriminatory practices.[90] What constituted discriminatory practice and how to enforce nondiscrimination was a legitimate quandary. Without strict rules and implementation procedures, there was no way of actively addressing and monitoring the racial disparities that plagued the nation. However, this changed in the health sector with Medicare and Medicaid revenues. Since there were federal funds, the disbursement or withholding of these monies became an important financial lever to incentivize nondiscriminatory practice. The Department of Health, Education and Welfare created a Hospital Civil Rights Compliance Protocol and certification program to monitor the situation. If a facility did not successfully integrate its clinical space and medical practice, it was denied federal funds. In 1967, during the first year of the programs' operation, 32 percent of hospitals revenues came from the government. This number would increase to over 50 percent in the years to come.[91] The financial incentive was instrumental in desegregating medical space, opening up care to non-white patients previously denied services, and generally increasing demand in historically understaffed and resource poor communities.

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[90] P. Preston Reynolds, "The Federal Government's Use of Title VI and Medicare to Racially Integrate Hospitals in the United States, 1963 Through 1967," *American Journal of Public Health*, 87(1997): 1851.

[91] David Barton Smith, "The Golden Rules for Eliminating Disparities: Title VI, Medicare, and the Implementation of the Affordable Care Act, *Health Matrix* 25 (33) 2015: 49, http://scholarlycommons.law.case.edu/healthmatrix/vol25/iss1/4; *The Power to Heal: Civil Rights, Medicare, and the Struggle to Transform America's Health Care System,* (Tennessee: Vanderbilt University Press, 2016).

Rise in medical service demand as a result of demography and legislative action occurred alongside social and cultural movements that changed *how* patients made demands of the medical establishment. A shift to a patient as consumer model and an understanding of healthcare access as a basic right challenged the doctor-patient power dynamic in important ways. A new "health care consumer" emerged during the interwar period and rose to prominence in the 1950s and 1960s. Nancy Tomes identified this individual as a predominantly white, middle class patient emboldened with a sense of "consumer protection and getting one's money worth."[92] Patients arrived at their doctor's office with an expectation of how they wanted to be treated and the kinds of treatments they sought.[93] This market-based orientation to care, Annemarie Mol's logic of choice, resulted in patients willing to take action if they were dissatisfied with the care they received.[94] Patients sought legal recourse for their perceived medical injuries resulting in a sharp increase in malpractice suits during the mid century. For the first time, patients received significant financial awards for their medical grievances.[95] However, medical grievances were not confined to the litigation. Few medical facilities, understaffed hospitals, and poor technological infrastructure were commonplace in hospitals that served communities of color, and frustration with this reality was palpable. As sociologist Alondra Nelson has argued, "health was a site where the stakes of injustice could be

[92] Nancy Tomes, "Merchants of Health: Medicine and Consumer Culture in the United States, 1900-1940," *Journal of American History*, 88(2001): 519-522.
[93] Footnote on alternative medicine at this time
[94] In Annemarie Mol, *The Logic of Care: Health and the Problem of Patient Choice,* (New York, Routledge, 2008), Mol explains that the concept of patient choice now dictates the terms of the clinical interaction instead of the doctor's care.
[95] James Mohr, "American Medical Malpractice Litigation," *JAMA*, 283(2000): 1736.

exposed and a prism through which struggles for equality could be refracted."[96] She located the Black Panther Party's free clinics and breakfast programs as an important space for health knowledge dissemination and black patient consciousness during the 1960s. Understandings of healthcare access changed from an inconsistent consumer demand reserved for the wealthy, to a belief that it was a right of citizenship for all Americans, irrespective of race.

In addition to the shifting locus of power in the doctor-patient relationship, there was an expansion in the very understanding of what was considered medical. Scholars refer to this as the medicalization of society, a new perspective of health in which the doctor's expertise extended "beyond biological and psychological phenomena relevant to the functioning, equilibrium, and fulfillment of individuals, to include social and cultural conditions of communal as well as personal import."[97] With this expansion, not only were patients' everyday experiences of social or emotional discomfort translated into diagnostic categories, but their political or sexual commitments could also be subjected to medicalization and pathology.[98] Jonathan Metzl's *Protest Psychosis: How Schizophrenia*

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[96] Nelson, *Body and Soul,* 5.

[97] Renee Fox, "The Medicalization and Demedicalization of American Society," *Daedalus,* 106(1977): 10-11. See also Peter Conrad, *The Medicalization of Society: On the Transformation of Human Conditions into Treatable Disorders,* (Baltimore: The Johns Hopkins University Press, 2007).

[98] Allan Horwitz and Jerome Wakefield, *The Loss of Sadness: How Psychiatry Transformed Normal Sorrow Into Depressive Disorder* (London: Oxford University Press, 2012), 6-8. Alan Horowitz and Jerome Wakefield find this particularly present in the interpretation of emotional and psychic states. They investigate the ubiquity of depression diagnoses in the latter half of the twentieth century and attribute this to a conflation of normal sadness with depressive disorder, resulting in an over diagnosis of the pathological condition. One important cause of the increased diagnosis is self-surveillance by people who experience sadness. While some individuals clearly present with a depressive disorder, others have internalized the medicalization paradigm and use this frame as a way to interpret their non-pathological, normal sadness. Ivan Illich and Thomas Szasz also pushed against medicalization. See Ivan Ilich, *Limits to Medicine: Medical Nemesis:*

Became a Black Disease and Ronald Bayer's *Homosexuality and American Psychiatry* exemplify the entanglements of the political, social, and medical along the axes of race and sexuality, respectively. In these scenarios and countless others, physicians were called upon to mediate events and phenomenon once considered outside of their jurisdiction.

The convergence of reduced physician supply and increased medical demand in the mid twentieth century caught legislators off guard. Motivated to take swift and decisive action, Congress passed the Health Professional Educational Assistance Act of 1963. Upon signing the legislation, President Kennedy declared the bill as only the inauguration of a "program of action" which required further emendation in the near future.[99] In line with this assessment, Congress updated the bill twice in the next ten years, once in 1968 and again in 1971. Both of these bills focused heavily on construction grants and other incentives that required significant time in order to produce the necessary number of physician ready to join the workforce. Although these measures were intended to increase the overall domestic physician pool, legislators understood that there was no guarantee that shortages would be lessened in rural and urban communities, where need was the highest. In response, they implemented a system of financial incentives to manipulate both the supply and placement of doctors. Over the objections of the AMA, a "shortage area program" was established to directly confront the problem. It contained a loan forgiveness and scholarship program, through which recipients received

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The Expropriation of Health (Marion Boyars, 1976) and Thomas Szasz, *Medicalization of Everyday Life: Selected Essays,* (Syracuse: Syracuse University Press, 2007).

[99] John F. Kennedy, "Remarks Upon Signing the Health Professions Educational Assistance Act," September 24, 1963, *The American Presidency Project*, http://www.presidency.ucsb.edu/ws/?pid=9425.

benefits in exchange for services rendered. A percentage of government student loans would be cancelled for every year of service. The scholarship program was based on a one to one ratio; for every year of government scholarship aid received for medical school, a person was required to practice in a shortage area for 12 months after graduation. The scholarship program was reserved for "(1) students from low income background residing in a shortage are who agree to practice there; (2) students residing in shortage area who agree to practice there; [and] (3) students from low income backgrounds."[100] In spite of these targeted programs, the fact still remained that the positive gains from these programs would not yield immediate results for many years to come. This was not the case with the Hart-Celler Immigration and Nationality Act of 1965. Extending an invitation to foreign physicians was strategic on two levels: it meant growth of the physician workforce in the United States with minimal cost and minimal delay and it announced globally that the United States was committed to diversity and economic openness. There was a place for the postcolonial foreign physician in the democratic bastion of the world.

Investments in Diversity

The mid-twentieth century was a time of global reconfiguration politically, economically, and ideologically. Politically, anti-colonial uprisings in Asia and Africa combined with the near memories of fascism and the ongoing nuclear arms race infused

[100] Owen McBride, "An Overview of the Health Professions Educational Assistance Act, 1963-1971," *Robert Wood Johnson Foundation* A1(1973): 13, http://files.eric.ed.gov/fulltext/ED111245.pdf.

political imaginations with pervasive totalitarian threat.[101] Economically, the post-WWII Bretton Woods conference aimed to reorient markets to promote open and free trade as an antidote to possible scarcity. Scarcity and security were intertwined phenomenon such that if scarcity existed, it was believed populations would revolt inciting insecurity followed by Communism.[102] And into this ideological Cold War moment, foreign physicians journeyed to the United States to forestall healthcare scarcity. However, FMGs posed a problem – the foreign physician could not be disaggregated from their labor. Thus, the only way to have medical services was to accept the medical practitioner. Acceptance took the discursive form of diversity and multiculturalism, a superficial gesture toward toleration with an underlying discomfort with difference. In the section that follows, these major geopolitical shifts are given a cursory introduction with the intention to acknowledge the complicated influences that informed the debates and the final version of the Hart-Celler Immigration Act.

For individuals of Asian origin, immigration to the United States, has consistently been racialized and intimately tied to questions of political economy. During the late nineteenth and early twentieth century, the US welcomed Asian workers (particularly Chinese, Japanese, Filipinos, and South Asians) as a source of cheap labor. However, these immigrants were barred from political participation through laws against

[101] I am invoking William Pietz's understanding of the term totalitarian. In "'The Post-Colonialism' of Cold War Discourse," Pietz argues totalitarianism was actually an idea devoid of historical object. Instead, it was an ideology "to enforce total control over language, the expression of ideas, and thoughts." In this understanding, communism, colonialism, and fascism could all be understood as totalitarian since each system attempted to produce a totalizing ideological apparatus.

[102] Michel Foucault, *Security, Territory, Population* (Picador, 2009), lecture 2.

naturalization and immigration exclusion acts.[103] As Lisa Lowe explains, "The contradiction between the economic need for inexpensive, tractable labor and the political need to constitute a homogenous nation with a unified culture was 'resolved' through legislation that 'racialized' Asian immigrants as 'non-whites'" and prohibited their participation in the nation-state.[104] The Immigration and Nationality Act of 1924 was the most comprehensive piece of immigration legislation prior to the 1965 Bill. The 1924 legislation consisted of two pieces of legislation: the National Origins Act and the Asian Exclusion Act. The Origins piece established an immigration quota system that severely limited migrants from southern and eastern Europe and the Asian Exclusion Act reiterated a zero tolerance policy in regards to Asian and Arab immigration. Senator William Fitts Ryan vocalized his disapproval of the quota system in a 1964 Congressional hearing: [The 1924 Act] cut the flow of immigration from southern and eastern Europe, as well as from Asia, and at the same time [offered] favorable immigration opportunities to members of what were then referred to as the Nordic or Aryan races. Call this what you may, it is nothing less than racial discrimination.[105]

The Cold War prompted scrutiny of the 1924 Immigration Act. Newly independent, post-colonial African and Asian nations were the sites of the Cold War battles and legislators understood immigration, as a proxy for foreign policy, was a useful ideological weapon against a Communist threat. Representative Edward Patten believed that "our unfair and unpopular immigration law discriminates against most nations of the

[103] Lisa Lowe, "The International Within the National: Asian Studies and Asian American Critique," *Cultural Critique* 40(1998): 31-32.
[104] Lowe, "The International Within the National," 32.
[105] U.S. Congress, House, Committee on the Judiciary, *Immigration: Hearings before the Committee on the Judiciary,* 88th Cong., 2nd sess., 1964, 219.

world, weakening our position of world leadership and handing Moscow readymade anti-West propaganda on a silver platter."[106] As the United States embraced its new global position as the "symbol of hope," policy makers held that the laws of the land must reflect this new responsibility. Opening immigration was an important route to establish transparent connections and create networks of information to monitor and surveil potential totalitarian threats.

The totalitarian threat incited fear and horror in governments and intellectuals alike. In 1953, the American Academy of Arts and Sciences assembled the best "scholarly and scientific"[107] efforts to investigate the mechanisms that permitted ideological movements of such dreadful proportions to take hold. Participants were bewildered by the surreptitious rise of German Nazism and Russian Communism and hoped that the rise of such terrifying regimes could be prevented if better understood. George Kennan, an architect of the post World War II Marshall Plan, identified the United States' sense of insecurity and obsessive preoccupation of with the totalitarian threat. He explained:

> We have come together to discuss the phenomenon of our time that has brought the deepest possible misery to untold millions of our contemporaries, even to the point of rendering life itself a hated burden to them. As a source of sorrow and suffering to the human race, I suppose this phenomenon has overshadowed every other source of human wellbeing in our times; for it has demeaned humanity in its own sight, attacked man's confidence in himself, made him realize that he can be his own most terrible and dangerous enemy, more bestial than the beasts, more cruel than nature. And although we Americans have not been directly affected by

[106] U.S. Congress, House, Committee on the Judiciary, *Immigration: Hearings before the Committee on the Judiciary,* 88th Cong., 2nd sess., 1964, 234.
[107] Freidrich, *Totalitarianism*, 1.

> it, to many of our countrymen it has come to appear as the greatest of all our American problems -- to some of them, I fear, as the only one.[108]

Attendees of the conference sought to provide insight into the initial mechanisms that catalyzed totalitarian regimes. They located a possible origin point in the consolidation of a singular ideology within a nation. Again, George Kennan elaborated on the negative aspects of this dangerous possibility: "Too great an urge for symmetry and order, too strong an insistence on uniformity and conformity, too little tolerance for the atypical and minority phenomenon: these are all things that can increase the path by which nations slide into totalitarianism..."[109] This was especially dangerous in large societies where local, social interactions were less frequent and "the individual can no longer sense or survey his relation to the whole and is obliged to feel himself, in the absence of the totalitarian illusions, as a helpless and superfluous entity in the hands of the demoniac forces beyond his power to understand or influence."[110] This detachment from a sense of wholeness could engulf an individual in totalitarian ideology making them unable to resist such a potent force of action.

Kennan, along with psychologist Erik Erikson, proposed diversity as a possible antidote. Together they wrote, "Diversity, in all the glorious disorder of nature, is the best defense of healthy societies."[111] In their estimation, the United States had a healthy relationship with diversity, proper checks and balances, and "deference to the vital

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[108] Kennan, George F., "Totalitarianism in the Modern World," in *Totalitarianism; Proceedings of a Conference Held at the American Academy of Arts and Sciences* (Cambridge: Harvard University Press, 1954), 17.
[109] Ibid, 29.
[110] Ibid, 26.
[111] Ibid, 29.

interests of competing minorities."[112] Properly managed difference was necessary to ensure that neither one vision, nor one language or one totalitarian idea was able to gain traction, thereby subsuming individual difference. Erikson supplemented the political argument with a psychoanalytic perspective explaining: "To have the courage of ones diversity is a sign of wholeness, in individuals and in civilizations."[113] He continued, "Wholeness seems to connote an assembly of parts, even quite diversified parts, that enter into fruitful associations and organization."[114] Thus, the ability of disparate pieces to coexist was an important aspect of a well adjusted individual and a properly functioning democracy, the necessary counter to totalitarianism.

As a possible method to resist totalitarianism, theorists suggested that diversity was especially important in the fragile postcolonial context where homogeneity of thought was the norm. In fact, as Hannah Arendt argued in *The Origins of Totalitarianism,* the contact between European Boers and "tribal" Africans is what solidified a totalitarian mentality in the Boers. Arendt explained the mob mentality crucial for totalitarianism to take hold was already a part of the nature of "decivilized" Boers who became nomadic, divorced from a proper public sphere and political activity during African colonization. This devolved nature was further ingrained as a result of contact with the natives "who lacked the specifically human character, the specifically human reality, so that when European men massacred them they somehow were not

[112] Ibid, 29.
[113] Erik Erikson, "Totalitarianism in the Modern World," in *Totalitarianism; Proceedings of a Conference Held at the American Academy of Arts and Sciences* (Cambridge: Harvard University Press, 1954), 171.
[114] Ibid, 161.

aware that they had committed murder."[115] To reiterate, because the Boers could not see Africans as humans, they killed them without reservation. As they continued to kill with abandon, killing became devoid of a moral valence and the Boers adopted a "tribal nationalism," premised on death and destruction thereby erasing any possibility of establishing a proper politically liberal society. As this bankrupt, terrifying thinking returned to Europe, it provided the precursor to a totalizing ideology. In Arendt's exposition of event, there are traces of victim-blaming – the colonized, who were singulary "tribal" provoked the destructive nature of the Boers. Therefore, to prevent to the totalitarian ideology from taking hold in postcolonial nations, which exhibited had a proclivity for "tribalism," it was incumbent on the West to monitor these spaces and infuse them with thought-ful diversity. US policymakers conceived of immigration as a method to deploy these practices. It was an effective ideological weapon to counter an insular, totalitarian mentality by signaling that borders were porous and the world was connected.

The commitment to openness, diversity, and transparency was most pronounced in the economic domain and exemplified in the 1944 Bretton Woods summit. The meeting agenda focused on freeing markets and reducing trade barriers to attain maximal openness and profit. By removing artificial controls and barriers, economic nationalism would end and capital could move in uninhibited ways unmoored from territorial constraints. The new vision of international economic connectivity would safeguard against any dire economic situations in participating countries, as economic scarcity was

[115] Hannah Arendt, *The Origins of Totalitarianism*, (Harcourt, Brace, and Jovanovich, 1973), 192.

seen as a gateway to totalizing regimes. Additionally, an unbounded, open market was a strategy to destabilize economic - mostly Communist - spheres of influence in hopes of ushering newly independent postcolonial nations into a democratic, capitalist order.[116]

The opening of markets was not exclusive to goods and capital; there were consequences for labor as well. While all of these commodities have a long mobile history beginning with the colonial encounter, a discursive articulation emerged during the Cold War period that valorized diversity and attended to culture in ways that were different than in previous eras. Labor, as Michel Foucault explains, in this new neoliberal world order included physical *and* psychological factors. The physical factors centered on the physical form of the laborer and the psychological factors included culturally distinct ideas, practices and influences from their communities of origin.[117] Together, the physical and psychological combined to produce the necessary conditions for an individual worker to earn a particular type of wage.[118] Given these multiple facets of the laboring human, "receiving countries [were forced] to create the necessary cultural preconditions" to accommodate diverse perspectives.[119] This meant the homogenizing, liberal articulations of the nation state located in an "imagined community" needed to

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[116] For more Bretton Woods and developmentalism, see Ben Steil, *The Battle of Bretton Woods: John Maynard Keynes*, *Harry Dexter White, and Making of a New World Order* (Princeton: Princeton University Press, 2013); Arturo Escobar, *Encountering Development: The Making and Unmaking of the Third World* (Princeton: Princeton University Press, 2011); James Ferguson, *The Anti-Politics Machine: Development, Depoliticization, and Bureaucratic Power in Lesotho* (Minneapolis: University of Minnesota Press, 1994), and James Scott, *Seeing Like a State*: *How Certain Schemes to Improve the Human Condition Have Failed* (New Haven: Yale University Press, 1999).
[117] Foucault, *The Birth of Biopolitics;* Bhiku Parekh, *Rethinking Multiculturalism: Cultural Diversity and Political Theory*, (Palgrave Macmillan, 2000) 8.
[118] Foucault, *The Birth of Biopolitics*, 224.
[119] Parekh, *Rethinking Multiculturalism*, 8.

undergo a revision to include the diversity and pluralism of labor. Multiculturalism was the symbolic and rhetorical product of this revision. It was an acknowledgement and a concession that the remainder of a person cannot be contained within the homogenizing vision necessary for a liberal, market based society. Therefore, it must exist on the outside, as something private, depoliticized and tolerated as long as it remains undisruptive to market operations. It was put forth "in liberal democratic societies when a hegemonic norm cannot colonize or incorporate its Other with ease."[120]

Despite the desire to silo culture and keep it within the realm of the private, it was an essential aspect of a human identity that warranted recognition according to political theorist, Charles Taylor. In "The Politics of Recognition," Taylor, a Hegelian who ascribes to the relational formation of individuals based on recognition, argues that this must be extended to the cultural identity of another: "Democracy has ushered in a politics of equal recognition, which has taken various forms over the years, and has now returned in the form of demands for the equal status of cultures."[121] This recognition was necessary for a productive moral and political life and must be achieved in a dialogical mechanism.[122] For humans to gain a sense of self, language was an essential mode through which to understand the inner being. This language of the internal, Taylor argued, was learned, understood, and articulated through "webs of interlocution" with those closest. Taylor writes, "identity doesn't mean that [we] work it out in isolation, but

[120] Wendy Brown, *Regulating Aversion: Tolerance in the Age of Identity and Empire (*Princeton: Princeton University Press, 2006), 74.
[121] Charles Taylor, "The Politics of Recognition," in *Multiculturalism: Examining the Politics of Recognitions,* ed. Amy Gutman (Princeton: Princeton University Press, 1994), 27.
[122] Taylor, "The Politics of Recognition," 32.

that [we] negotiate it through dialogue, partly overt, partly internal, with others."[123] However, Taylor is quick to defend against the suggestion that recognition is reducible to the a mere reflection of the thoughts and opinions of other. It is an active process that facilitates a particular type of authentic identity formation. This idea of an authentic identity that is particular to a person or a group is foundationally important to the logics of multiculturalism.[124][125]

Taylor identifies two competing modes of recognition that operate in the public sphere in regards to multiculturalism and its associated politics of recognition. One is a Kantian universalizing ideal that locates a "universal human potential," and requires respect for all humans by virtue of their humanness.[126] Within a democratic model, this politics of universalism takes on the form of the "equalization of rights and entitlements,"[127] and is centered on a difference blind ideology. In contrast to this idea is the politics of difference and identity, which is the basis of multiculturalism. While this formulation also has a universal character, it requires that all people "should be recognized for his or her unique identity."[128] The distinctness of people and their unique cultural character cannot be disregarded and subsumed within universalist configurations

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[123] Taylor, "The Politics of Recognition," 34.
[124] Taylor, "The Politics of Recognition," 38.
[125] Critics of Charles Taylor such as Bhiku Parekh and Kwame Anthony Appiah note, this authenticity easily blurs into an essentialism that can lock a person in a particular social location and ignores the mutability of identity. Taylor rejects this critique by arguing that identity formation is a dialogic into perpetuity and thus, constantly able to change. See Parekh, *Rethinking Multiculturalism* and Kwame Anthony Appiah, "Identity, Authenticity, Survival: Multicultural Societies and Social Reproduction," in *Multiculturalism: Examining the Politics of Recognitions,* ed. Amy Gutman (Princeton: Princeton University Press, 1994).
[126] Taylor, "The Politics of Recognition," 41.
[127] Taylor, "The Politics of Recognition," 37.
[128] Taylor, "The Politics of Recognition," 38.

because universalist ideals reflect a particular hegemonic worldview and allow the rise of a dominant monoculture that dangerously denies difference. Scholar David Theo Goldberg explains, "monoculturalism purports to universalize the presuppositions and terms of a single culture, and it likewise denies as culture any expression that fails to fit its mold of high culture."[129] It denied individuals a distinctive identity, which Taylor saw as a grave consequence.

During the Cold War, multiculturalism and diversity were politically promoted as important aspects of liberal democracies in contrast to totalitarian regimes. Goldberg argues this discursive pivoting from totalitarianism to multiculturalism should be understood as an exercise in reproducing the Cold War formations of First and Second World: "knowledge production, sustained and constrained by monocultural presumptions, played a crucial role in perpetuating the cold war division between East and West, and thus, in covering over a certain confluence of colonizing interests vis-à-vis the "Third World." Historian Nikhil Pal Singh echoes this observation stating that the sense of multicultural urgency in this period "developed in the United States in a very particular time and place and in a specific relationship to the question of world order."[130] There was a direct link between the nationalistic impulses present in the notion of "world order" and the global political imaginary of the United States. Culturally and rhetorically, the country fashioned itself as a nation that exemplified internal democracy through the "harmonious cooperation of different groups within the vast national body and the broad

[129] David Theo Goldberg, *Multiculturalism: A Critical Reader* (New York: Wiley, 1995), 5.
[130] Nikhil Pal Singh, "Culture/Wars: Recoding Empire in an Age of Democracy," *American Quarterly*, 50(1998): 473.

toleration of cultural, religious, ethnic, and racial differences in the US."[131] The language of universal tolerance was ostensibly extended to all forms of differences and tolerated within a liberal democracy. A humanist ethics of recognition fueled this ideological stance and informed policymakers' perspectives in regard to the Hart-Celler Immigration and Nationality Act.

The totalitarian threat was managed through multiculturalism and diversity and immigration was one strategy to operationalize this ideological perspective. It explains why when Dr. TA entered the US embassy in Pakistan for his visa interview in 1973, he was asked one singular question by the interviewing officer, "Are you a Nazi?" Dr. DA answered no and was granted permanent residency in the United States on the spot. The ideological fear of totalitarianism lingered nearly two decades after the physical threat was neutralized. The passage of immigration legislation during this period was not coincidental. It provided two important political purposes: immigration was a way to diversify publics through the promotion of multiculturalism, a strategy that valorized an essentially depoliticized identity, and it was also a tactic to know, document, and monitor bodies with a potentially threatening postcolonial past. By passing through the juridico-political apparatus of immigration, bodies were counted and made accountable.

Importing a Solution

In the years leading up to the Hart-Celler Act, legislators feebly gestured towards immigration reform. The McCarran-Walter Immigration and Nationality Act of 1952 allowed a 100-person quota for peoples of the Asia Pacific Triangle. Those included in

[131] Singh, "Culture/Wars," 490.

this newly imagined "Asia Pacific Triangle" included "all countries from Pakistan to Japan and the Pacific Islands north of Australia and new Zealand. [Additionally,] if so much as one half of an immigrant's ancestry came from the Asia-Pacific triangle, he must come within the small quota assigned…regardless of the place of his birth." Senator Spark Matsunaga of Hawaii explained that this law said to the peoples of Asia and the Pacific, "We think you are inferior and therefore let only a token number of you enter our country."[132] Between the McCarran-Walter Act and the Hart-Celler Act, Congress addressed immigration in a piecemeal fashion at times permitting a small number of skilled immigrants or converting other immigrants into non-quota status. Congressman Emmanuel Celler, co-author of the Hart-Celler Act disparaged these small shifts in legislation; "instead of clean surgery we have indulged in operations of occasional blood infusion into a moribund system." Celler agitated for a significant overhaul of the system.

In the 1960s, Celler and his supporters considered immigration reform the last bulwark in America's commitment to the "vital principle of equality."[133] Congress approved Civil Rights legislation the year before and advocates argued that immigration reform was part of the fight against racism. Celler envisioned the post 1965 immigrant as a potential American, temporarily housed in another land due to the "accident of his birth." Celler asked, "shall we not as a nation have the means whereby we can choose freely from all corners of the earth the talents and the skills we need and not limit our choice because one man of genius was born 5 miles east or south of an arbitrarily traced

[132] U.S. Congress, House, Committee on the Judiciary, *Immigration: Hearings before the Committee on the Judiciary,* 88th Cong., 2nd sess., 1964, 251, 253.
[133] U.S. Congress, House, Committee on the Judiciary, *Immigration: Hearings before the Committee on the Judiciary,* 88th Cong., 2nd sess., 1964, 440.

boundary?"[134,135] His rhetoric not only reaffirmed American Exceptionalism, but it also signaled a shift in immigration policy towards a new wave of "genius" elite immigrants deserving of unbounded movement possibility. And on the condition of their talent and productive capacities, they were welcomed to the United States as potential Americans.

The sponsors of the 1965 Immigration Act chose selective immigration with preferential categories as the most politically and economically strategic way to reform immigration. These changes erased the foreign policy stain of restrictive immigration while simultaneously endorsing an open capitalist United States. Selective migration was emphasized for immigrants who could fulfill specific labor shortages, of which skilled scientists and medical professionals were at the top of the list. This immigrant was permitted to enter on the assumption that they could "make a contribution to the country, can help the economy, can better further our skills, our culture, and our understanding."[136] Robert Kennedy allayed fears regarding the quality of these immigrants by reassuring the Congressional committee that "our standards for admission are so high that the immigrant workers are predominantly educated and skilled. They do not take unskilled jobs away from our unemployed." [137] This new immigrant was an elite, laboring body, different from previous iterations of the immigrant. They no longer performed jobs Americans rejected, instead, they contributed brainpower America lacked.

The overwhelming consensus about the Immigration Bill was that it gave both the United States and potential immigrants the power of choice: America will have its choice

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[134] U.S. Congress, House, Committee on the Judiciary, *Immigration: Hearings before the Committee on the Judiciary,* 88th Cong., 2nd sess., 1964, 195.
[135] Ibid, 6.
[136] Ibid, 419.
[137] Ibid, 417.

of immigrants and the immigrants will have the choice to move to America. Secretary of State, Dean Rusk, explained:

> We are moving into a scientific and technologically sophisticated period of our national history and there is going to be plenty of room at the top. We are drawing on other countries …because they have the talent and the background, which make them extremely helpful in our society here. I would think we would want to keep those channels open and make it clear that there is an opportunity here for those who would like to take up their lives with our own. We are in an international market of brains… This is not a case of deliberately going out to rob.[138]

The Dean of the University of Texas Medical School, Charles Sprague, agreed with Rusk's perspective stating medical professionals are world resources and "should have the freedom of movement to any country where they can be maximally productive in answering problems that are not unique to a single country, but are problems of the world. We should never interfere with the migration of this category of health personnel."[139] Sickness and health were universal problems that paid no attention to the bordered confines of a nation state. Any understanding of these issues in one country would eventually trickle down. So why not start in America?

. Secretary Rusk and Dean Sprague dismissed the accusation that America was unapologetically pilfering top talent from less "developed" nations. Instead, they framed the movement within the broader logics of globalization, which trenchantly took hold during the Cold War. Rusk and Sprague identified the main components of this worldview: dissolution of nationally bound markets in favor of a global marketplace, and the importance of ideas and cultural products in this exchange. Rusk's statements reflect

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[138] Ibid, 401.

[139] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 63.

theorist Sassia Sasken's view that the objective of globalization is to create an international division of labor with a homogenizing cultural component., Sasken identifies immigrant labor as "a distinct category of labor" within the system of global capital and located national boundaries as the sites through which nation-states circumscribe the conditions for this distinctive labor.[140]

Within the new discourse of globalization, the mobile laborer was simply searching for "opportunity" on the "international market of brains." In *The Birth of Biopolitics,* Michel Foucault explains that in the post World War II era, migration from the point of view of the migrant is an investment in the acquisition of human capital. Although there is a material and psychological cost for an individual who decides to migrate elsewhere, they do so to invest in themselves, to improve their social status or income. Foucault interprets the immigrant as "an investor. He is an entrepreneur of himself who incur expenses by investing to obtain some kind of improvement." Thus, migration becomes a "behavior in terms of individual enterprise" and supports the capitalist human "abilities-machine."[141] Economist Walter Adams, head of the Lausanne Conference on Brain Drain, voiced this perspective in his testimony before Congress in 1968 explaining, "professional people with a readily marketable skill like medicine, are highly mobile on the international market," and qualified physicians should settle where it was possible to maximize personal gain.[142]

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[140] Saskia Sassen, *The Mobility of Capital and Labor: A Study in International Investment and Labor Flow* (Cambridge: Cambridge University Press, 1988), 37-38.
[141] Foucault, *The Birth of Biopolitics*, 229-230.
[142] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 55.

Although the Hart-Celler Act garnered much formal support in Congress, the hearings leading up to the vote exposed discord percolating just underneath. Proponents of the legislation often expressed their support using two major arguments: a structural, macro world systems approach, which espoused a belief in an unbound global marketplace that could be relied on to place laboring bodies wherever needed and another which was more microeconomic centering individual choice. Opponents derided these perspectives arguing that purely economic arguments for immigration reform were devoid of ethical consideration. They ignored larger moral considerations regarding America's position in the new global order and its responsibilities towards developing other countries, not extracting their elite professionals. Although the debate leading up to the Immigration Bill vote was contentious, the legislation passed with large majorities in both the House and the Senate. For the first time, significant legal immigration from Southern Europe, the Caribbean, and Asia was possible, especially for immigrants with particular credentials. Foreign Medical Graduates were among the largest professional groups to enter the United States, with a majority arriving from the Philippines and India.[143] These foreign elite laborers were used as an expedient measure to address the doctor shortage crisis while US medical reform efforts established in 1963 incubated. The advocates of this plan hoped that FMGs would be the front line against the deluge of demand facing an ill-equipped healthcare system.

Brain Drain

In a 1968 Congressional hearing on *Brain Drain*, Congressman Peter Rodino

[143] Stevens et al., *The Alien Doctor* (New York: John Wiley & Sons), 5.

asked his fellow politicians, "Does it not follow that the countries to whom we would look for the skilled specialists would feel that we would be draining off their best people, those whom they would want to keep and wouldn't this give rise to some feeling which would not enhance our relations with these countries?"[144] Although espousing the minority opinion in this matter, Rodino vocally expressed concerns about the movement of talent from "developing" to "developed" countries, and its consequences on broader political relationships. Rodino's comments were an attempt to reintegrate the political and ethical aspects of elite migration into a debate largely framed along economic logics. His question forced a confrontation between the rhetorical framing of the bill aimed to promote interconnectivity and prosperity for all with the reality that the United States was accruing elite labor at a cost to sending countries. On the one hand, the urgency surrounding this immigration reform was framed in terms of America's moral position as the harbinger of democracy. Yet, on the other hand, in the spirit of this unity and collective movement towards democracy, was it not the moral responsibility of the United States to continue to support democracy and development within these newly independent postcolonial nations instead of allowing top talent to emigrate to the United States?

Individuals willing to articulate this position grew in the years after the passage of the 1965 Immigration Act. Senator Walter Mondale brought attention to the issue on the Senate floor calling the situation a "national disgrace." He wrote in the *Saturday Review*, "That we should…need doctors from countries where thousands die daily of disease to

[144] U.S. Congress, House, Committee on the Judiciary, *Immigration: Hearings before the Committee on the Judiciary,* 88th Cong., 2nd sess., 1964, 463.

relieve our shortage of medical manpower is inexcusable."[145] Allowing elite laborers permanent residence in the United States compromised US "commitment to development by depriving new nations of high-level manpower indispensible to their progress. It runs counter to the education and training we provide in our foreign aid." These development grants for education and training where a part of the "vital long-run objectives of American foreign policy," he wrote, adding that, "American security depends on development in the less developed countries; development at sufficient speed to satisfy at least a portion of their rising aspirations."[146] Critics argued that the Brain Drain threatened development, painting it as a threat to democracy and US security. Dr. Kelly West of the University of Oklahoma explained the situation in less abstract terms, particularly in relation to physicians. The dollar value of the manpower being derived through immigration "to the United States approximately equals the total cost of all our medical aid, private and public to foreign nations."[147] Thus, real advantages of development aid were accrued by the United States.

Ultimately, foreign physicians offered a cost effective solution to doctor shortage. "Importation of medical skills is much cheaper for us than developing our own facilities."[148] Professor William Thiesenhusen testified before Congress and explained, "[the] expense of developing ample facilities to prepare [United States] citizens to fill our current professional medical void… would be the cost of operating 12 new medical

[145] Walter Mondale, "How Poor Nations Give to the Rich," *Saturday Review*, March 11, 1967, 25, http://www.unz.org/Pub/SaturdayRev-1967mar11-00024?View=PDF.
[146] Walter Mondale, "How Poor Nations Give to the Rich," *Saturday Review*, March 11, 1967, 25, http://www.unz.org/Pub/SaturdayRev-1967mar11-00024?View=PDF.
[147] U.S. Congress, House, Committee on the Judiciary, *Immigration: Hearings before the Committee on the Judiciary,* 88th Cong., 2nd sess., 1964, 24.
[148] Ibid, 30.

schools – to say nothing of [the cost] of building them."[149] Foreign physicians completed medical school, most often through government subsidized training facilities, and arrived in the United States able to provide medical services. US investments in medical facilities and tuition subsidies were inapplicable to these practitioners making them an attractive strategy to bypass the national labor inefficiencies. Additionally, explained economist Walter Adams, with the ""cartel-like, guild restriction" established by the American Medical Association, which operated as "an impediment to the proper functioning of the free market within the [US]" domestic production of talent would never satisfy increasing demand.[150] In his expert opinion, immigration was necessary to compensate for the artificial shortages precipitated by AMA politicking. However, Adams stressed, immigration should be used only as a temporary, short-term solution.

This warning went unacknowledged in regards to foreign physicians. Beginning in 1965, a new, elite, Asian immigrant arrived, changing the color and ethnicity of doctors in the United States. With brown skin, accented English, a colonial past and a modern medical education, the Asian doctor provided medical services in return for eventual legal US citizenship. When signing the Hart-Celler Act into law, President Lyndon Johnson claimed the legislation "was not a revolutionary bill" and "it does not affect the lives of millions [and] it will not restructure the shape of our daily lives."[151]

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[149] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 39.
[150] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 55.
[151] Lyndon B. Johnson, "Remarks at the Signing of the Immigration Bill," October 3, 1965, http://www.lbjlib.utexas.edu/johnson/archives.hom/speeches.hom/651003.asp.

However, he was wrong when it came to medical care. FMGs provided important medical services in inner city and rural communities, taking care of considerable patient populations until today.

Conclusion

In the mid twentieth century, America was on the precipice of a doctor shortage crisis. During the height of the Cold War, broadcasting this deficiency had the potential to compromise the country's political and ideological legitimacy both locally and internationally. Policymakers turned to immigration legislation as a strategy to augment the labor supply quickly as well as a signal to the world that the United States rejected its closed, isolationist orientation of the past and embrace its role as the global superpower. President Kennedy urged legislators to revise the illogical and unreasonable national origins quota based immigration system put in place in 1924, and instead design a policy promoting "the new era of interdependence amongst nations." [152] This interdependence eventually facilitated the migration of thousands of foreign physicians from postcolonial nations into the underserved hospitals of America.

Changes to immigration policy reflected a changing relationship to the concept of a closed, bounded nation-state. Memories of closed totalitarian regimes haunted political discourse. Advocates of multiculturalism and diversity championed these ideological positions as an antidote to a secretive threat lurking within. The insistence on opening up the United States by Kennedy and Celler was also intended as a statement of difference. It was a defensive declaration that the United States was not closed like totalitarian states,

[152] John F. Kennedy, Immigration message John F. Kennedy, "Immigration Message," July 23, 1963, *The American Presidency Project*, http://www.presidency.ucsb.edu/ws/?pid=9425.

it was a welcoming and transparent democracy. Ideological motivations for restructuring the Immigration Act of 1924 were combined with the practicalities of the labor market; the United States severely lacked scientific and medical expertise and the national policies implemented required a lengthy gestation. Importing elite labor was an efficient and cost effective solution to reduce shortages. Within "the international market of brains," there existed an undeniable directionality in the movement of elite labor.[153] The consequence of this migration for the development of exporting countries was largely ignored in favor of free market logics. As economist Walter Adams explained: "The brain drain can be a primary catalyst to stimulate a nation to initiate change and self-generation – an incentive to modernize and adapt to the exigencies of powerful international market forces."[154]

Immigration produced anxiety within the nation. This was no different in the case of the foreign physicians. To manage this concern, the bureaucratic document became an important epistemological way of knowing a person. In paper, the uncertainty of the foreigner could be fixed, assigned a particular identity and regulated. In the next chapter, I trace the journey of South Asian foreign physicians from country of origin to their care sites in the United States. This process required a bureaucratic transformation and conversion of a foreign physician through documentary procedures. The documents of the foreigner were not only a necessary for immigration purposes, they were also a primary site of national recognition.

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[153] Stevens et al., *The Alien Doctor,* 1.

[154] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 55.

CHAPTER 2: PAPERING OVER DIFFERNCE

The Hart-Celler Act of 1965 passed during a time of contradiction. The political demands of an open, multicultural democracy were threatened by suspicious Cold War logics. And the economic demands of a market, driven society confronted legislative actions to direct foreign labor. The entanglement of these demands made urgent questions of identity and elevated obsessions with transparency. Foreign physicians arrived in the United States amidst these tensions as unknown persons claiming to possess knowledge and expertise. Because of their conditional entry into the country, foreign physicians' political identity was primarily understood through processes that emphasized a professional identity. Therefore, to be made into US citizens, it was simultaneously necessary to be made into US sanctioned doctors. As thousands and thousands of FMGs arrived from Third World countries to provide medical care, it became a political necessity to know these foreigners, to uncover false identities and expose potential deficiencies.

State and local bureaucracies were responsible for overseeing and validating a foreign doctor's presence in the United States. As scholars have previously shown, the ideological, amorphous State is actualized in the lives of a population via proceduralism and bureaucratic structures.[155] It is in the routinized and banal bureaucratic mechanisms of forms, applications, and files that boundaries are defined, permissions granted, and

[155] Max Weber, *Economy and Society: An Outline of Interpretive* Sociology ed. Guenther Roth and Claus Wittich (California: University of California Press, 1978); *Anthropology in the Margins of the State* ed. Veena Das and Deborah Poole (Sante Fe: School for Advanced Research, 2004); Gupta, *Red Tape;* Hull, *Government of Paper*.

people transformed. Although these systems often seem innocuous and objective, they are important sites where cultural norms are created and inculcated and social inequalities are produced and reproduced.[156] Bureaucratic management was integral to FMG formation as it converted diverse medical practitioners into something verifiable and compatible with US standards and metrics. Documents became the primary route through which FMG identity in the United States was configured and proscribed.

In this chapter, I follow the journey of a FMG from country of origin to work placement in the United States, paying particular attention to bureaucracy and the documentation necessary for migration. For foreign physicians, the paper life became a foundational mode of political recognition. The chapter begins with a brief exploration of FMG motivations for migration, followed by a stepwise recreation of the bureaucratic procedures necessary for immigration and clinical practice. Medical competency exams, certificates of completion, and licenses operated as vital regulatory mechanisms through which foreignness was negotiated. Compiled together, these documents constituted an archive of expertise, a documentary disclosure necessary to be considered legitimate practitioners as well as potential American citizens. However, while documents could verify a person, they also had the potential to falsify a FMG. The final section of the chapter investigates the relationship between claims of FMG fraud and documentary authenticity.

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[156] Veena Das and Deborah Poole, "State and its Margins: Comparative Ethnographies" in *Anthropology in the Margins of the State* ed. Veena Das and Deborah Poole (Sante Fe: School for Advanced Research, 2004), 13.

Documents mediated between a particular medical knowledge obtained outside of the United States to a universal, standard medical knowledge and negotiated the transition from a postcolonial subject to a modern, liberal citizen.[157] The relationship between bureaucracy, identity, and documentary practices is long-standing, originating as a colonial method used to classify and differentiate subjugated populations.[158] Its legacy as a rational, modern, objective form of governance has persisted into the present through the continuity of bureaucratic inscriptional practices and logics.[159] In attending to these practices for FMGs coming to the United States, I uncover the work FMGs undertook to make themselves legible to bureaucratic systems. Phrases such as "un*document*ed immigrant" and "having *papers*" highlight the discursive linkage between documentation and immigrant subject formation. As such, to achieve political recognition in the United States, the paper presentation of self became an important practice for personal identity and professional possibility.

Motivations for Migration

King Edward Medical University in Lahore, Pakistan is the oldest and most prestigious medical institution in Pakistan. Drs. TA and KB, both graduates of King Edward, explained students studied for the entrance exam from the age of thirteen because competition for entrance was notoriously difficult. However, upon completion of

[157] Stevens et. al, *The Alien Doctor*, 23.
[158] Irene Silverblatt, *Modern Inquisitions: Peru and the Colonial Origins of the Civilized World* (Durham: Duke University Press, 2004); Laura Bear and Nayanika Mathur, "Remaking the Public Good: a New Anthropology of Bureaucracy," *Cambridge Anthropology* 33(2015):18-34; Laura Bear, "The Antinomies of Audit: Opacity, Instability and Charisma in the Economic Governance of a Hooghly Shipyard," *Economy and Society*, 42(2013): 375-397.

[159] Hull, *Government of Paper*, 11.

their medical degree, many graduates emigrated from Pakistan to England or the United States. Dr. TA remarked, "of the year ahead of me [1975], only two people stayed back in Pakistan…In my class of 154, there were probably three or four left in Pakistan. Everyone else went outside."[160] Dr. BK, a graduate of the only medical college in Damascus, Syria, left for his postgraduate training because, he explained, there were "no possibilities to specialize in my home country. Everyone went for training in Europe or the United States. My classmates in the school were all preparing to come to the United States. I felt compelled to keep up with my classmates…peer pressure sent me to America."[161] These doctors recall a momentum, a forgone expectation around their departure from their country of origin. The path to the United States was available and there was little reason to stay behind. Colleagues who made the journey to America previously often encouraged and supported migration providing information, accommodations, and financial support. FMGs relied on these forms of sociality to mitigate the various barriers to migration as well as orient their lives upon arrival in the United States.

"The United States was the buzz word, the future, better medicine," Dr. BK answered when asked about his expectations regarding America. This sentiment was repeatedly articulated in interviews, where foreign physician explained their desire for more from their medical practice than what was possible in their countries of origin. Dr. M shared a story of a young boy in need of a blood transfusion due to complications from

[160] Dr. TA, interview with Eram Alam, Westchester, New York, March 5, 2016.
[161] Dr. BK, interview with Eram Alam, Burr Ridge, Illinois, March 9, 2015.

a ruptured spleen. The difficulties associated with this case influenced his decision to leave India. He narrated:

> I remember a 10 or 12-year-old kid who slipped from the bus and hit his spleen and was bleeding internally. I was on call and slowly his blood pressure was falling and he needed blood. The system was such that the surgeon would come and operate during the day and go away…[I was the only one there] and there was no blood available. If you wanted blood, there were some people who used to sell blood…We used to send the security guard who stood outside of the room to go to a close by railway station and he would ask the qu'li [sic], and those were the people who sometimes used to sell blood and they would know which group was which and they would bring them in to give blood...and then we had to do cross-matching, so you can imagine how slow the process was. The kid died in the middle of the night. People [Doctors] were afraid to take action because they thought that this was a serious case and the result will not be good and I don't want a bad reputation…There everything goes on reputation and the doctor is blamed for everything…But those are the issues with all of the Third World countries.[162]

Frustrated with the speed of medical care and the social aspects of medical practice, Dr. HM left India hoping for a medical environment where he could provide care that was patient centered, and less doctor focused. Dr. NS, another Indian physician described his desire for knowledge as insatiable. Regularly frequenting US Information Agency offices in India to read recent medical and scientific journals from the United States, Dr. NS was committed to keep abreast of cutting edge urology practices. However, despite reading these articles and understanding the procedures and research contained in them, his medical practice lacked the resources and infrastructure necessary to perform the new techniques.[163] Dr. NS's migration to the United States was prompted by this frustration and an awareness of a possibility for better patient care elsewhere.

[162] Dr. HM, interview with Eram Alam, Oak Brook, Illinois. July 26, 2015.
[163] Dr. Navin Shah, interview with Eram Alam, June 14, 2014, Potomac. MD.

When justifying the migration of skilled professionals to the United States, experts on the "Brain Drain" often alluded to these feelings of general dissatisfaction. In 1968, in a statement before Congress, Dr. Charles Kidd argued that professionals would be more inclined to stay in sending countries if their was an "increase receptivity to changes." He continued, "this new elite human capital refuses to accept traditional values and power relations. It is an ambitious, able, impatient, and above all mobile class which threatens the stability, inertia, and conservatism of traditional societies…it searches out the social environment receptive for innovation."[164] These "traditional societies" were compromised by years of extractive colonial rule contributing to their lack of an "environment receptive for innovation." Kidd went on to disparage colonized countries explaining, "India, like most ex-colonies, apes its former imperial master by teaching the same curricula the same way – without attempting to adapt its educational product to local needs and without adjusting for its different economic development. Most of the less developed countries because of national pride (or self-delusion) – insist on producing high level manpower in larger quantities than foreseeable demand."[165] Decimated by years of colonial rule, newly independent Asian nations predictably had limited biomedical infrastructure and resources. And within the neocolonial developmentalist logics in place during the Cold War, it was unlikely that these countries would economically recover in any substantive way soon.

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[164] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 55..

[165] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 57.

Additionally, the political situation in the 1960s and 1970s in South Asia significantly intensified the desire to emigrate. Pakistani doctors frequently mentioned avoided conscription as an important motivating factor for their movement. There was aggressive military recruiting taking place in the country because of the Bangladesh Liberation War, a gruesome war for independence between East Pakistan (Bangladesh) and West Pakistan, and multiple Indo-Pakistani Wars. Recruitment officers targeted medical personnel because the military was suffering a doctor shortage. Dr. KB hid from military personnel to avoid conscription while waiting to depart for the United States. "Friends would tell us, they [army recruiters] are in Karachi today," and Dr. KB made sure to avoid the area.[166] Other physicians chose to migrate to nearby countries in the short term to avoid military service. Dr. NK went to Iran for a year where he took his ECFMG exam and secured passage to the United States. "If I had not gone to Iran…I really didn't want to go to the army. It was a way for me to get out [of Pakistan]. It was a stepping stone for me to get to the West."[167] These Pakistani physicians left their country to avoid military service sometimes occupying vacancies in the United States left by physicians recruited during the Vietnam War. Cycles of war produced perpetual global shortages.

There were even rumors in the 1970s that the Pakistani government would disallow the Educational Council for Foreign Medical Graduate (ECFMG) exam in the country to thwart the mass exodus of physicians. The ECFMG was an exam administered by the United States and mandatory for physician migration discussed in the next section.

[166] Dr. KB, interview with Eram Alam, New York, March 5, 2016.
[167] Dr. NK, interview with Eram Alam, Chicago, July 25, 2015.

Although the details are vague, Dr. Charles Kidd reported, "India has forbidden the administration of the test required for entrance of physicians in the United States." To circumvent this, physicians such as Deepak Chopra, advisor to Oprah Winfrey, went to Sri Lanka to sit for the exam.[168] Chopra's ability to travel to Sri Lanka highlights an important economic aspect of physician migration. Often, though certainly not all, Indians able to attend medical school and immigrate enjoyed a privileged position in their home countries. In the case of Chopra, his father was a notable medical officer under the British colonial government. As Roger Jeffery in *The Politics of Health in India* and Anil Kumar in *Medicine and the Raj* argue, the British government made a concerted effort to recruit medical students from upper caste and class backgrounds to bolster the prestige of the profession. This colonial lineage continued after independence reproducing the class and caste hierarchies in the cohort of medical students motivated to join the US labor force.[169] However, without proper documentation, migration was not possible.

A Case for Immigration

Charles Sprague, Dean of University of Texas medical school, raised an important concern regarding the global supply of medical labor entering the United States. If, "when a foreign medical graduate comes to this country, his educational background, his goals and objectives and the educational system he finds himself a part of, do not necessarily match up," then what must be done to ensure that they do eventually match

[168] Aziz Haniffa, interview with author, Washington DC, September
[169] Roger Jeffrey, *The Politics of Health in India;* Anil Kumar, *Medicine and the Raj*.

up?[170] In other words, what are the steps required to create and maintain a transposable, commensurate supply of global medical labor? And could they be trusted and relied upon to efficiently and effectively provide care for US patients? These questions overwhelmed US medical institutions as they struggled to create oversight procedures. As Mary Douglas writes in *How Institutions Think,* "Before it can performs its –entropy reducing work, the incipient institution needs some stabilizing principles to stop its premature demise. That stabilizing principle is the naturalization of social classification."[171] In 1956, the American Medical Association, American Academy of Medical Colleges, and the US government established the Educational Council on Foreign Medical Graduates (ECFMG) to manage the uncertainty of a global medical manpower. It was originally created during the Cold War to in response to an influx of physicians largely from post WWII Europe and to monitor visitors under the Fulbright Exchange program. [172] Upon creation, the stated goals of the organization were as follows:

> To give graduates of recognized foreign medical schools an opportunity to establish their qualifications for undertaking advanced medical training in United States hospitals, and to provide hospitals, state board of medical examiners, and specialty boards with the means of identifying those foreign medical graduates who were qualified to assume places as interns and residents and those who were not.[173]

The ECFMG had the unenviable task of deciding what criteria to use to "recognize foreign medical schools", defining what constituted "qualified," and identifying foreign

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[170] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 63.
[171] Mary Douglas, *How Institutions Think* (Syracuse: Syracuse University Press, 1986), 48.
[172] James Hallock, "Celebrating 50 Years of Experience," *Academic Medicine* 81(2006): S7.
[173] James Hallock, "Celebrating 50 Years of Experience," *Academic Medicine* 81(2006): S8.

medical graduates thoroughly. Their mission was to make foreign physicians legible to American healthcare system through bureaucratic procedure. Similar to the observations Geoffrey Bowker and Susan Star make in *In Sorting Things Out: Classification and its Consequences* regarding international consensus on disease categories and the role of bureaucracy, the ECFMG had to assemble a protocol to manage the transnational migration of foreign physicians.[174] It became an obligatory institutional passage point for FMGs throughout their careers.

The first step in the ECFMG certification process was successful passage of the ECFMG exam and a validation of medical credentials. The exam consisted of two parts and was routinely administered at US embassies around the world as a recruiting tool for foreign physicians. Friends and colleagues pooled limited books and resources transforming studying for the exam into a communal endeavor. The most difficult aspect of the process, explained Dr. HM, was feeling that "everything was a trick, every question and every possible multiple-choice answer." Educated in Hyderabad, India, Dr. HM relied on generous subsidizes from his family while he committed a year to preparing for the exam. In an interview, he recalled his frustrations:

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[174] *In Sorting Things Out: Classification and its Consequences,* focus on the messiness of ordering large global phenomenon. In their study of the International Classification of Diseases, Bowker and Star highlight the "tangled and crisscrossing" schemes of organization held together by "bureaucracy." Although their work focuses on disease categories, its attention to the role of bureaucratic procedure to organize global knowledge is analogous to the case of foreign physicians. See also: Ian Hacking, *Taming of Chance* (London: Cambridge University Press, 1990); Sheila Jasanoff, "Biotechnology and Empire: The Global Power of Seeds and Science," *Osiris*, 21(2006); Ludwik Fleck, *Genesis and Development of a Scientific Fact* (Chicago: University of Chicago Press, 1981).

> The method was totally different; the approach was totally different…You have to study the books, which are followed here. Our system didn't have multiple-choice. We never heard of multiple choice [in India]. In our system they would give you ten questions and they will say typhoid. So then you have to say what is typhoid, what is the bacteria that causes that, what are the signs, what are the symptoms, what is the outcome and all that and you have to answer that in three or four pages, and then another disease. That was the format there. And along with that you had the oral exams…We had to get used to different things [for the ECFMG exam]. And some [other things were emphasized.] For example, what is the incidence of a disease in a particular population? There was nothing like this concept in India or the prevalence in a certain population of whites or blacks.[175]

Foreign physicians performed an epistemic revision of their medical training in order to succeed on the exam and obtain the requisite certificate. Ways of knowing and seeing illness that were grounded in a particular place and effectively prepared physicians to provide care in their countries of origin were distorted and distilled to fit within the US system of language and examination. While the argument can be made that the foreign physicians aspired to practice in the United States and thus should have a US knowledge base, this epistemic revision can also be understood using Charles Taylor's insights on hegemonic cultural structures in modern liberal democracies. He writes, "dominant groups tend to entrench their hegemony by inculcating an image of inferiority on the subjugated. The struggle for equality must pass through a revision." FMGs' local, provincial medical knowledge was reformatted into a transcendent, universal standard through the exam. Typhoid was no longer understood in terms that would fill four blank pages; it was transformed into the letter c in a list of multiple choices. And the ECFMG exam certificate documented the requisite transformation. This document operated as the object through which transnational migrations and movements of FMGs were made

[175] Dr. HM, interview with Eram Alam, Oak Brook, Illinois. July 26, 2015.

possible and eventually coordinated. [176] It had the capacity to "transform, translate, distort, and modify the meaning or the elements [it carried]."[177] The certificate operated as a temporal hinge between years of completed medical knowledge from the country of origin and future possibility in the United States. It was the first document in the case for immigration. The next was a visa.

During the ten years following the passage of the Hart-Celler Act, FMGs were given preferential visa status to boost the US workforce rapidly. There were multiple possible routes for entry that were often overlapping and regularly changed. Dr. TA, a physician from Pakistan mentioned in the previous chapter, arrived for his visa interview at noon on November 11, 1976 with his ECFMG certificate and medical diploma in hand. The first question the US consular officer asked was "were you ever a Nazi?" Dr. TA replied, "Nazi? I was born in 1953!"[178] Within the hour, he was granted permanent resident status. Without securing employment, he arrived in the United States less than a month later on December 4, 1976.[179] Dr. TA's situation was not as common as entry with a J-1 visa. This visa, instituted during the Cold War as a diplomatic tool to foster educational exchange between the United States and other countries, was readily extended to foreign physicians. J-1 visa status was designed for people from abroad to receive educational training in America and return to their home country. The return requirement was initially relaxed for FMGs and they converted their J-1 visa to

[176] Hull, *Government of Paper,* 253.
[177] Bruno Latour, *Reassembling the Social: An Introduction to Actor-Network Theory* (London: Oxford University Press, 2005), 39.
[178] Dr. TA, interview with author, Westchester, New York, March 5, 2016.
[179] Dr. TA, interview with author, Westchester, New York, March 5, 2016.

permanent resident status upon completion of their residency training easily.[180,181] Statistical data compiled by the ECFMG showed that "roughly 70 percent of the 9,518 FMGs who were under ECFMG sponsorship in 1972 had become permanent residents by 1975."[182]

The Department of Labor further complicated FMG immigration. In 1965, the Department notified its overseas consulates that a foreign physician could apply for permanent resident status in the United States without ECFMG certification. This measure was intended to expedite the staffing of federal facilities specifically, since state licensing required the exam. A physician could apply if they graduated from a foreign medical school, had some sort of license to practice medicine in their home country, and worked previously for two years as a doctor. As a consequence of this, federally run facilities including psychiatric hospitals and prisons employed a considerable contingent of FMGs who received permanent resident status for their medical labor without passing the ECFMG exam.[183] They practiced medicine with temporary permits issued for work within a particular governmental facility. The use of these permits "represents an expedient means of locking in these physicians once they have been successfully recruited," explained Dr. Robert Taylor, program chief for Mental Health Services for

[180] Stevens et. al., *The Alien Doctor*, 62-63.
[181] Vinod Agarwal and Donald Winkler, "Migration of Professional Manpower to the United States," *Southern Economic Journal* 50(1984); 823.
[182] U.S. Congress, House, Committee of the Judiciary, *Foreign Medical Graduates: Hearing before the Subcommittee on Immigration, Citizenship and International Law,* 95th Cong., 1st sess., 1977, 3
[183] AAMC Position Statement, "Graduates of Foreign Medical Schools in the United States: A Challenge to Medical Education," *Journal of Medical Education* 49(1974): 830.

Marin County, before a Congressional Committee in 1974.[184] However, the number of FMGs admitted to the federal system was insignificant compared to those granted J-1 visas.

While waiting for the visa application to clear in their country of origin, FMGs were tasked with finding a job and securing passage to the United States. This, like much of the immigration process during this time, was haphazard. In interviews, FMGs frequently identified informal transnational networks of information as a key resource for employment opportunities. Dr. N recalled learning of a residency job opening from a relative doing his medical training in Akron, Ohio. This relative mailed him the application, which he completed and sent back. After a few months, the hospital offered Dr. N a staff position and a plane ticket. In another example, Dr. B, Pakistani physician, received advice from older colleagues working as residents in the greater New York area. Upon their suggestion, Dr. B searched for job opportunities in foreign journals available at US Information Agency offices in Lahore. Healthcare institutions and training programs advertised openings in these foreign journals offering to pay travel costs and guide foreign physician through the state licensing process.[185]After applying for many positions, Dr. B received an attractive offer and a plane ticket from Queens General in Jamaica, New York. He landed at JFK international airport and took a taxi straight to the

[184] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 731.
[185] James Spilsbury and Margaret Cooney, "Immigrant Health Care Providers in the United States," *Handbook of Immigrant Health*, 609.

hospital. Dr. B was given a room and told to report to duty in the ER the next day.[186] He was asked to provide care without a state license.

Because medical licensure was a state function, there was considerable variation between states. Senator Edward Kennedy described it as "a crazy quilt pattern."[187] This disjointed process was complicated requiring a varied compilation of documents and possibly another state specific medical competency exam. State licensing boards were wary of the ECFMG exam and the knowledge it purported to certify. They argued that the ECFMG was simply a basic science and medicine exam and an English exam that anyone could study for and pass, even without a proper medical education. The ECFMG exam was an inadequate screening tool and could never properly replace the process of education and training that US medical graduates received. In 1974, Dr. Robert Weiss from the Center for Community Health and Medical Care at Harvard University commented on the problem:

> American medical education has been subjected to a whole series of controls on the process of education…It is clear that control of a minimal level of educational process and certification does assure that U.S. medical graduates have been observed and certified on their professional competence before being tested on just their level of medical knowledge. There are increasing numbers of FMGs, immigrating to the United States educated in medical schools in developing countries. Most of these countries do not exercise any control over student selection or the educational process. Last year approximately 80 percent of the FMGs entering the United States had been educated in the Asian countries. The substitution of the ECFMG exam for the complex system of controls developed for U.S. medical graduates as the sole measure of the FMGs competence to enter

[186] Dr. KB, interview with Eram Alam, New York, 5/5/2016,
[187] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 399.

> the U.S. health care system has resulted in a double standard for the minimal control of physician manpower.[188]

The idea for the state licensure exam was that it would assess and measure "fitness for practice," not just basic medical information. However, this metric proved very difficult to define and evaluate.

To tackle the problem, the Federation of State Medical Boards proposed a new, universal exam called the Federation Licensing Exam or FLEX.[189] The Federation of State Medical Boards was an organization established in 1912 with the primary objective of assisting state medical boards in their process of licensing and ensuring that states instituted "high and uniform" standards for medical licensure.[190] In the early 1960s, the Federation assembled state board members and charged them with designing an exam to assess clinical practice, and the "application of medical knowledge with patient-centered questions that posed a problem requiring a licensure candidate to demonstrate the ability to transfer theoretical knowledge into diagnosis, treatment, and patient management."[191]

Over the course of the 1960s, most states adopted the national FLEX exam. However, this uniform exam did not translate into uniform scoring as states established different cutoffs, asserting "states-rights" over medical licensure. Dr. Thomas Piemme of the George Washington University Medical Center elaborated on the process: "after the exam is graded by the National Board of Medical Examiners, an organization working in

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[188] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 635-636.
[189] David Johnson and Humayun Chaudhry, *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards* (Maryland: Lexington Books, 2012), 156.
[190] Johnson and Chaudhry, *Medical Licensing and Discipline in America*, 59.
[191] Johnson and Chaudhry, *Medical Licensing and Discipline in America*, 123.

concert with the Federation of State Medical Boards, the score is submitted to the state board and the "state has the right to do with that score whatever it chooses."[192] This meant that a state could ignore the recommended passing score of 75% and lower its passing threshold to grant more physicians a passing score. In response to this practice, Dr. Robert Weiss explained that states can "set its priorities for staffing in public institutions [prisons, mental health facilities, and public hospitals] and very often look the other way and bend the requirements." FMGs struggled with this exam for similar reasons as the ECFMG exam. However, states kept requirements low to ensure enough foreign physicians made it through to fill vacancies in undesirable medical institutions.[193]

For foreign physicians, the path to licensure was still incomplete after the FLEX exam. Dr. Robert Derbyshire, a long time member of the Federation of State Medical Boards, commented during a Congressional hearing: "[FMGs] run into a series of extra requirements when he wants a license, when he wants to move from one State to another…These people [FMGs] are completely bewildered by this."[194] The final step in the process was submitting a case with a compilation of carefully collated documents for state board approval. This assemblage of documents for bureaucratic purposes was an essential step in establishing what Matthew Hull by way of Max Weber describes as a

[192] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 778.
[193] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 747.
[194] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 774.

"regime of control."[195] Documents assert a bureaucratic control through their "links to the entities they document" and "through the coordination of perspectives and activities."[196] The process of acquiring and submitting a case for licensing was confounding and frustrating for many FMGs. General bureaucratic practices and ways of assessment in country of origin were incommensurable with informational organization and method in the United States. And even after the state process, there was the issue of obtaining hospital privileges. There was no guarantee that hospital administrators would approve of the documents.

In the years to come, FMGs waged a political battle against organized medicine and the government urging them to remedy problems with medical licensure.[197] Navin Shah, an important organizer for the cause, explained that FMGs were required to collect data on their medical professors, obtain transcripts in particular ways, and fill out numerous forms detailing their medical education. They were asked to provide answers to questions including whether and to what extent teaching staff published research articles, the quantity and quality of basic lab equipment, and the number of books available in their medical school library.[198] Shah explained the difficulty saying, "They would ask to provide letters from my professors, but some of my professors were dead already. Why don't you ask me how many girlfriends my professor had because that's as

[195] Matthew Hull, "Documents and Bureaucracy," *Annual Review of Anthropology*, 41(2012): 255.
[196] Matthew Hull, "Documents and Bureaucracy," *Annual Review of Anthropology*, 41(2012): 257.
[197] This will be detailed in chapter 4.
[198] Dr. Navin Shah, interview with Eram Alam, Potomac, MD, February 28, 2015.

irrelevant as a professor writing about when I was a student [over ten years ago]."[199] He interpreted this as an illogical exercise, transparently disguised as a process for maintaining bureaucratic order. Shah understood these extra forms and questions as an exercise in creating and maintaining difference between US medical graduates and foreign physicians. It was a technique to provoke feelings of inadequacy and shame. Through the use of emotionally evacuated bureaucratic forms, he was forced to engage in a kind of introspection that inevitably resulted in his conception of self as lacking. Having to answer that the library contained 1000 medical books or that there were 15 microscopes evoked a sense that there should have been more and that his educational experience would have been of greater quality if these objects were available.

The medical establishment considered bureaucratic management of the FMG labor pool urgent -- a lack of proper oversight could have detrimental consequences for the medical profession and patient populations. Medical authorities experienced a palpable anxiety regarding the nature of this difference and engaged in much discussion about how to manage the foreign physicians. Evaluating biomedical facts and testing English were the first steps in the process. However, an exam was insufficient for assessing clinical skill and bedside manner. To reduce anxiety, documentary practices were used as a governance technique to convert postcolonial physicians into a universal workforce. Documentation was a strategy to concretize elusive social relations embedded in a particular time and place and turn them into portable, measurable manifestations. Similar to the way obtaining US citizenship through marriage requires assembling an

[199] Dr. Navin Shah, interview with Eram Alam, Potomac, MD, February 28, 2015.

archive of love to convince an evaluator of affective authenticity, FMGs produced an archive of their expertise to establish medical authenticity. Producing this archive of documents and cases was a bureaucratic exercise aimed at combatting uncertainty and doubt. It was a "condensed site of epistemological and political anxiety,"[200] intended to eliminate the possibility of fraud or prevent the rise of a seedy medical underground outside of the medical establishment's purview.

Fraudulent Foreigners

Historically in the United States, organized medicine consolidated power and authority by actively targeting and removing "frauds" from the ranks of the profession. This antagonistic label was used against women, alternative healers, and non-white professionals over the years and continued with foreign physicians.[201] The medical establishment feared FMGs' unknowability and worried these practitioners diluted the integrity of the profession. The Dean of Columbia Medical School voiced this concerns regarding FMGs in *The New York Times*: "The result is the creation of two standards of medical care, the first for patients treated by first class [US] graduates…and the second for patients being treated by [foreign medical] graduates of unrecognized medical

[200] Ann Stoler, *Along the Archival Grain*, 19.

[201] The history of professional consolidation will be explored in more detail in chapter 3. On frauds and alternative healers, see: Robert Johnston, *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America* (New York: Routledge, 2004); Roy Porter, *Quacks: Fakers and Charlatans in* Medicine (London: Tempus, 2003) Note: this is about London; Roberta Bivins, *Alternative Medicine?* (Oxford: Oxford University Press, 2010); Natalie Robins, *Copeland's Cure: Homeopathy and the War Between Conventional and Alternative Healers* (New York: Knopf Books, 2005); Fred Frohok, *Healing Powers: Alternative Medicine, Spiritual Communities, and the State* (Chicago: University of Chicago Press, 1992); James Young, *Medical Messiahs; A Social History of Health Quackery in Twentieth Century America* (Princeton: Princeton University Press, 1967); James Whorton, *Nature Cures: The History of Alternative Medicine in America* (Oxford: Oxford University Press, 2004).

schools."[202] Despite suspicions and negative characterizations, FMGs were integral to the functioning of the healthcare system. In 1977, Dr. James Dickson, the Secretary of the Department of Health, Education, and Welfare reported:

> Between 1963 and 1973, approximately 65 percent of the net increase in the physician to population ratio in the United States is attributable to alien physicians…Nationwide, approximately 1/3 of the graduate medical education positions, internships, and residencies have been filled by foreign graduates. In 1972, a peak year, 46% of new licenses to practice medicine issued in this country was issued to FMGs.[203]

Foreign doctors worked largely in community and public hospitals in New York City, Chicago, Baltimore, Newark, and Philadelphia or rural areas, providing care for considerable patient populations.[204],[205] Organized medicine maintained a fraught relationship with foreign physicians. On the one hand, foreign physicians were accused of reducing the standards of the profession; and on the other, they were essential for medical care. The tenuous relationship between the two groups was most noticeable in overt, and sometimes subtle, allegations of fraud. In these instances, the document was an important object to arbitrate truth claims. It became a formal structure that was "easily recognized" and endowed with "self-validating truth."[206]

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[202] "Alien Doctors Reduce Standards in Nation, Columbia Dean Charges," *The New York Times,* Feb 8, 1954, http://query.nytimes.com/mem/archive/pdf?res=9C02E2DB153CE43ABC4053DFB466838F649EDE

[203] U.S. Congress, House, Committee of the Judiciary, *Foreign Medical Graduates: Hearing before the Subcommittee on Immigration, Citizenship and International Law,* 95th Cong., 1st sess., 1977, 50.

[204] Rosemary Stevens et al., *The Alien Doctor,* 6.

[205] Irene Butter and Richard Schaffner, "Foreign Medical Graduates and Equal Access to Medical Care," *Medical Care* 9(1971): 136-137.

[206] Douglas, *How Institutions Think*, 48.

In 1976, the *Chicago Sun Times* reported the story of Dr. Kandaswamy Balasubramaniyam, a "Fake Doctor Who Performed Brain Surgery":

> An Indian man fooled officials of three states into thinking he was a doctor has performed delicate brain surgery in an Illinois hospital.…in January when Illinois authorities discovered he was not a doctor. Illinois revoked his medical license. Acting on an indictment from that state, Alaska officials cornered him in an Anchorage rooming house Saturday…Dr. B arrived in Illinois in 1976 and got a medical license on the strength of what were later discovered to be forged medical diplomas and other credentials. The Chicago Sun Times discovered that between then and January, Dr. B. practiced in at least two hospitals and performed brain surgery at least once at a Chicago hospital. He turned up in Anchorage last Monday where he got a temporary Alaska medical license, apparently using forged documents identical to those given to Illinois authorities and licensing officials in Kentucky where he still holds a medical permit. Nurses at the hospital said Dr. B. insisted he was a doctor.

Dr. Balasubramaniyam entered the United States as an elite professional migrant and was accused of exploiting the mobility facilitated by his medical credentials. He practiced in three different states using "forged medical diplomas and other credentials" and even performed brain surgery. What became of his case is uncertain. Nevertheless, Dr. B.'s story, while clearly exceptional in nature, highlights the fear and sense of risk that organized medicine felt in regards to this unknown labor pool and raises many questions.

Dr. B was understood and validated through licenses, irrespective of the care he provided. Licenses were important artifacts not only because they allowed a physician to practice medicine, but they also carried the bureaucratic weight of their production. They signaled that the licensee was properly identified, located and had an acceptable history, in addition to medical knowledge. These objects silenced Dr. B's insistence that he was a doctor until the end and draw attention to a possible limitation of bureaucratic legibility. While the details and extent of the forgery are unknown, Dr. B could have been a

competent physician, but his medical school may not have been found on the WHO list of approved medical schools used by the ECFMG or his answer to questions about the number of books in his medical school library may not have been high enough. Ultimately, he was indicted on 74 counts of Medicare fraud, not malpractice. Perhaps Dr. B's insistence that he was a doctor was not without merit. In this case, the documents arbitrated truth and rendered him a fraud. Through the documents, a certain form of knowledge was recognized and other information was disqualified. This incident highlights the tension that Ann Stoler identified in competing regimes of truth[207]: the documents versus the insistence of the person. In this case, the documents judged Dr. B as a fraud as the paper artifacts endowed with "self-validating truth."[208]

Fear of an undocumented, underground network of medical practitioners further amplified distrust and suspicions of FMGs. Through various visa configurations and immigration routes, some physicians managed to enter the United States without the sponsorship of the ECFMG or an ECFMG conferred passage of exam certificate. The exact numbers are uncertain and probably small, but the existence of these unlicensed, untethered doctors fed into fears of a rapidly expanding "medical underground."[209] These mostly Asian, unlicensed individuals were called "doctor" because they held medical degrees from abroad, wrote journalist Lawrence Altman in 1974. He explained, "But the patient might not know that the doctor was unlicensed" and probably practicing without

[207] Stoler, *Along the Archival Grain,* 43.
[208] Douglas, *How Institutions Think*, 48.
[209] Stevens et. al, *The Alien Doctors*, 80-83.

supervision. Some "do surgery in operating rooms or in the emergency wards. Others give anesthesia. Many practice psychiatry."[210]

These "underground" physicians were not simply deceiving the medical system; they were, in fact, an integral part of its proper functioning. A special article in the *New England Journal of Medicine* entitled "Foreign Medical Graduates and the Medical Underground" investigated the involvement of these physicians in the daily functioning of hospital life and patient care. The study showed that "[unlicensed FMGs] are usually employed under nonphysican titles… and are taking night calls, covering emergency rooms, delivering babies, prescribing preanesthetic medication, writing x-ray reports. They are doing history and physical examinations. Some of those known as pathology assistants are reading frozen sections on which a surgeon determines whether or not to do a radical procedure. Some of them are doing fluoroscopy."[211] Some unlicensed FMGs reported performing minor surgery and a few reported performing major surgery.[212] Hospital administrators employed the "medical underground" as a cost effective strategy during a time when operating costs were increasing and hospital budgets declining. They paid these physicians lower salaries because they "cannot demand the same wage that

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[210] Lawrence K. Altman, "Many foreign physicians in U.S. Found Unlicensed," *The New York Times,* June 20, 1974, http://query.nytimes.com/mem/archive/pdf?res=9402E5DD1131EF34BC4851DFB066838F669EDE

[211] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 639.

[212] Robert Weiss et. al, "Foreign Medical Graduates and the Medical Underground," *New England Journal of Medicine* 290(1974): 1411.

they would get if fully qualified"[213] explained Dr. Robert Weiss, author of the study. On average, these doctors received under $10,000 a year in salary.[214]

Dr. TA, a physician from Pakistan, earned much less than this when he arrived for work at New York University's main hospital. He arrived in New York City with five hundred dollars, the maximum amount one could transport, and began calling hospitals looking for a job.

> [I wanted anything], even if it meant working for free. I was willing to volunteer or anything. In February of 1977, I happened to call NYU…and they were one person short [in their intern year cohort]. At that point, I had exactly one dollar left in my pocket and I showed up for the interview. They said we can't hire you as an intern, but we will hire you as a subintern for sixteen dollars per week…So I started working there as a subintern, we call them killer interns [because of the amount of work that is dumped on you], and worked like an intern. After about a month of that, my resident went up to the chairman of medicine and said, 'you know you're exploiting this poor, scared, immigrant. He's a physician and you're treating him like dirt. You should pay him [more].'[215]

Dr. TA was eventually given a raise and continued working in this capacity for another five months. His case illustrates how FMGs were often understood through readily available tropes of foreignness and cheap labor. Nevertheless, as long as he completed required tasks, this prestigious medical center was willing to keep him on staff.

Documents, Duplicity, and Doubt

Bureaucratic procedures were imbued with a detached objectivity that obfuscated social mechanisms embedded within them. Compiling documents in a particular way and

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[213] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 640.
[214] Robert Weiss et. al, "The Effect of Importing Physicians – Return to a Pre-Flexnerian Standard," *New England Journal of Medicine,* 290(1974): 1457.
[215] Dr. TA , interview with Eram Alam, Westchester, New York, March 5, 2015.

the technicality of forms – these practices played a significant role in determining professional possibilities for a foreign physician. In a series of letters between Dr. T and the Director of Medical Affairs at a suburban hospital in Illinois, contested documentation played a central role in adjudicating hospital privileges. Dr. T completed his training at Bangalore Medical College in 1975. In 1988, after having worked in the US for over ten years, he intended to start a private medical practice and applied for privileges in a local hospital. Dr. T's request was denied for two reasons: the documentation provided had only initials for his last and middle names, and his medical school transcripts and certificates were hand delivered to the hospital, instead of mailed directly from the medical school to the hospital. Dr. T's reply to the Director who denied him hospital privileges is quoted at length below:

> Regarding my last and middle names being initialized, I had enclosed a copy of an article from an Indian magazine, which I thought provided the explanation. All the documents I have in my possession have my name written that way. It is a cultural, geographic, and local practice from the area of the country I come from to write names that way. I wish you would provide me an opportunity to show you all the original documents I have in my possession to substantiate this fact.
>
> Regarding the documents being hand delivered to your office, it took me more than three months, several phone calls and many trips from my relatives in India to the medical school to obtain the documents. I hope you would appreciate the practical difficulties in obtaining letters from 10,000 miles away for a graduate who completed medical school nearly 13 years ago. I understand that you're protecting the credentialing process and your protectionist policies, which unfortunately, affect only Foreign Medical Graduates. I am also aware that several Foreign Medical Graduates and Americans have fraudulent credentials, but I've been in this country for more than eight years. You have letters and scores of other documents in support of my application [from your US peers.] To fool or convince all of these professionals for the past several years must make me darn good at my profession![216]

[216] Letter from Dr. T to hospital director, personal archive, Navin Shah, Potomac, MD.

Dr. T received a short and terse reply to his over two page explanatory letter. The Director basically replied: "I can't interview you or submit your application."[217]

The first issue with the application, the way Dr. T's name was written, raised questions as it suggested the possibility of a false identity. The importance of names or naming as a proxy for identity and knowing are sites of modern subject formation and essential to structures of governance and management. Foucault theorized the modern form as text and argued that the literal organization of the form, the construction of spaces and boxes suggests a proper way of identifying oneself.[218] It is in these seemingly insignificant bureaucratic normalizations and demands that power is exerted. The cultural norms and practices that were sufficient to identify Dr. T and structure his existence in the country of origin are incommensurate with the spaces on US bureaucratic forms. He is forced to defend his Otherness by providing an explanation for his supposed misnaming. However, Dr. T's additional cultural explanation and "objective" newspaper article cannot overcome his illegibility. The form is still incomplete. The document mediated between schemes of classification utilized in India and the US, and the Director's rejection of the additional cultural explanations can be understood as an indictment of a less developed bureaucratic ethos. In the end, Dr. T was required to articulate his subject position with the supposed objectivity of the physical form. Unless he produced himself within the allotted space and translated his personhood properly, Dr.

[217] Letter from Director to Dr. T, personal archive, Navin Shah, Potomac, MD.
[218] Foucault, *Disciple and Punish*; For an example, see: Liisa, Malkki, *Purity and Exile: Violence, Memory and National Cosmology among Hutu* (Chicago: University of Chicago Press, 1995).

T's identity was questioned and understood as inauthentic and unverifiable in the United States.

The method of document delivery was the second problem with the application. The issue raised in this objection was the possibility of falsified educational credentials. While documents are assumed to contain authenticity and truth, in practice, this notion is contingent upon sites of production and conditions of receipt. Because of the difficulty in managing and deciphering global medical education, there must exist some level of institutional trust and belief in a universal logic of bureaucratic management. Without adhering to modern standards of information delivery, the very nature of the document becomes suspect. Dr. T implores the Director to consider the "real practice difficulties in obtaining letters" from medical schools from "far off lands," to which the Director wrote back, "I am sorry that your medical school fails to answer your requests [for transcripts to be sent directly to the hospital]. It does not reflect well on them."[219] This episode highlights the temporal connection created through documents between the moments of document making and the moments of evaluating. The Director's remarks on the failure of the Indian medical school to adhere to his conceptions of standard operating procedure intimates a disdain for the medical school itself. In this statement, there is an easy slippage from a negative impression of the bureaucratic practices of the medical school to the quality of its education and graduates. In this evaluative capacity and role, the application and proper documentation must adhere to a particular set of procedural

[219] Letter from Director to Dr. T, personal archive, Navin Shah, Potomac, MD.

standards that will elevate the quality of the documentation provided. Any data or circumstance outside of this frame is rendered either insignificant or invisible.

Dr. T supplied additional letters of support from US peers to bolster his application. The purpose of these documents was to vouch for his capabilities as a medical professional. It was a compensatory strategy for his hand delivered medical transcripts. His invocation of the nationality of the letter writers suggests an internalization of his subject position within the American medical establishment and recognition of his second-tier status.[220] It was a subtle articulation of his relationship to his social position within the United States. This was the psychological harm Frantz Fanon and Charles Taylor attributed to misrecognition. Historically, colonial and postcolonial institutions of governance have relied heavily on documents in lieu of people as material objects with the capacity to vouch for a person or an action.[221] In the case of Dr. T, the letters of support authored by *US peers* are invoked to prove his legitimacy and expertise. He hoped that the influence and status of the letter writers and their willingness to actually produce such a letter would increase the persuasiveness of his petition for privileges. The letters of support submitted indexed "relations of accountability"[222] and a "hierarchy of credibility"[223] that elevated the reference writer's word over Dr. T's documents.

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[220] Starr, *The Social Transformation of American Medicine*, 360.
[221] Hull, *Government of Paper,* 8. Add leviathan and the air pump, concepts of witnessing.
[222] Steve Woolgar and Daniel Nyeland, *Mundane Governance: Ontology and Accountability* (London: Oxford University Press, 2014).
[223] Stoler, *Along the Archival Grain*, 23.

Ultimately, the case had an unfavorable outcome. The Director wrote in his final reply: "I have been ordered to discriminate against incomplete applications." Invoking bureaucratic logics, the Director distanced himself from the decision in two ways. Firstly, procedural orders were to blame for the denial of privileges and secondly, the discrimination that he was ordered to perform was against the incomplete application, not the person of Dr. T. The Director located agency outside of his jurisdictional authority and placed it within an amorphous, bureaucratic system with strict rules for a proper application.[224] By divorcing himself in this way, he infused the document technology with an agentic position and capacity for judgment. Using the incompleteness of the application as the reason for the denial, the Director emphasized that the rejection was predicated on an analysis of the case, not on a biographical analysis of Dr. T.[225] The case analysis allowed for a masking of the sociality of the document, while a biographical analysis could potentially veer into an affective dimension and divorce the procedural action from its need for uniformity, standardization, and objective rationality. The biographical analysis would focus on how Dr. T "acts on and shapes the world" instead of how the case was constructed.[226] Weber refers to this as the bureaucratic demand for the calculability of rules. "Bureaucracy develops the more perfectly…the more

[224] Gupta, *Red Tape*, 148.
[225] Carol Heimer, "Conceiving Children: Bow documents Support Case Versus Biographical Analysis" in *Documents: Artifacts of Modern Knowledge*, ed. Annelise Riles (Ann Arbor: University of Michigan Press, 2006), 108.
[226] Heimer, "Conceiving Children," 111.

completely it succeeds in eliminating from official business, love, hatred, and all purely personal, irrational, and emotional elements which escape calculation."[227]

Secondly, implicit in this exchange is the possibility of Dr. T himself being a fraud, not just the documents he provided. Most likely, the fear of being identified as a fraud prompted Dr. T's defensive response and willingness to provide additional documentation. Given the suspicious stance of the medical establishment towards FMGs, his reaction regarding the authenticity of the documents and by extension himself, was part of what Matthew Hull describes as a "graphic regime of surveillance." Dr. T was compelled to disclose himself because "procedurally correct documents compel compliance not because the documents they generate supersede the realities they purport to represent, but because bureaucratic procedures embed documents in those realities." Producing data on oneself in this way is a reminder to FMGs that their histories are documented and can be retrieved at any moment. It is a way of inscribing power relations such that the asymmetry between the producer and the possible evaluator is always present. This knowledge imprints a certain way of being and practicing medicine on a FMG that is oriented and organized through proper documentation and ensures a predictable future. If a foreign physician transgressed behavioral norms and expectations, the archive of their case file would either vouch for them or give them up as inadequate frauds.

Conclusion

[227] Weber, *Economy and Society,* 975.

During the Cold War, at a time of heightened paranoia and anxiety, foreign physician entered the United States to provide medical care. With the greatest percentages arriving from postcolonial nations, the urgency to know the foreigner was pressing. To this end, organized medicine and the US government created the ECFMG, a quasi-governmental body tasked with standardizing, certifying, and guiding these practitioners. To accomplish their objective, documentary practices became a central technique to coordinate and manage FMGs. Certificates, forms, documents, and files were assembled into arguments for entry and acceptance into the US polity. These apparently stable bureaucratic products were "devices for handling objects characterized by motion,"[228] symbolic artifacts that connoted institutional acceptance in the Unites States. While it is certainly true that US medical graduates also had to take exams and file for licenses, the foreign physician's experience of this practice was different. The way foreign physicians were asked to produce themselves in documentary form, the kinds of disclosure, and the excessive scrutiny of their medical care established a different relationship to the documentary form. It was an immigrant's relationship to the document, which is the primary site for inclusion into the nation. Therefore, the documents not only testified to their medical abilities, they legitimated their citizenship possibilities. Documents made the foreign physician transparent to US publics in a way that was not necessary for their US counterparts whose inclusion was assumed.

The particular conundrum of medical care was that it required two types of knowledge: biomedical facts and clinical skills. And proficiency in one did not guarantee

[228] Arjun Appadurai, *Globalization* (Durham: Duke University Press, 2001), 5.

proficiency in the other. Proper documentation produced some standard to judge biomedical fact knowledge, but clinical skill was difficult to police. The AMA was particularly disparaging in their opinion of foreign doctors abilities in this regard. Masked in the language of quality and performance, organized medicine delivered racialized critiques of FMGs. They warned that foreign physicians posed a double threat to both US doctors and US patients. Nevertheless, their value to the healthcare system was undeniable. Although they were often deemed inadequate, slow, or unable to learn, foreign doctors were given more responsibility than the average US Medical Graduate in the same position.[229] Mr. Chapman of the Bureau of Educational and Cultural Affairs explained, "some hospitals were creating special fellowship training programs to prolong the stay of the FMG", and most hospitals were primarily concerned with the "services" the FMG rendered rather than providing training opportunities.[230] Hospital administrators even went so far as to circumvent national medical standards in order to attract and maintain their foreign staff.

After FMGs completed the bureaucratic steps required to migrate from country of origin and enter US clinical practice, they had to negotiate their new professional identity in the clinical setting. In the next chapter, I analyze the clinical encounter paying particular attention to how FMGs became medical experts and subsequently enacted this expertise. This required a certain performativity and the continual production of expert

[229] Irene Butter and Richard Schaffner, "Foreign Medical Graduates and Equal Access to Medical Care," *Medical Care* 9(1971): 136-137.
[230] U.S. Congress, House, Committee of the Judiciary, *Foreign Medical Graduates: Hearing before the Subcommittee on Immigration, Citizenship and International Law,* 95th Cong., 1st sess., 1977, 4.

status in social situations. Two sets of interactions are particularly illustrative: those between FMGs and the US medical establishment and those between FMGs and their US based patient populations.

CHAPTER 3: FIRST CONTACT

The "golden age of medicine," was descendent when Asian foreign physicians entered the medical system in the 1960s. The popular press maligned doctors' profit driven orientation and emotionally devoid patient care.[231] No longer the sacerdotal practitioner of the early 1900s performing their craft in the intimate setting of the home, these new doctors were accused of performing a job instead of responding to a higher calling. They were technical in their orientation to care, distant in their patient interaction, and resistant to any government intervention in the mechanistic operations of the profession. Organized medicine was intransigent in response to criticism and territorial in the face of possible jurisdictional encroachment. During this time, physician's assistants, nurse practitioners, and reemerging midwives encroached upon physician autonomy and threatened physician fees. Cumulatively, these changes had the effect of seriously challenging the authoritative mantle organized medicine constructed during the "golden age of medicine."

At the turn of the twentieth century, the medical profession embraced more of a corporate structure, replacing a loosely connected aggregate of associated individuals model. The corporate structure consolidated the profession through mechanisms such as professional associations, medical education requirements, licensing procedures, and

[231] John Burnham, "American Medicine's Golden Age: What Happened It?" *Science* 215(1982): 1474-1479.

accreditation standards.[232] These measures institutionalized a virtual medical monopoly by predominantly white, upper class men, who established internal control mechanisms to perpetuate their power and create professional closure around themselves. In the middle of the twentieth century, the expansion of Medicare and Medicaid, rising health care costs, third party payer systems, and patient advocacy and consumerism disrupted organized medicine's autonomy and control. And to disrupt the profession further still, foreign doctors joined the professional ranks compromising the carefully crafted identity of the profession. Their presence into this professional domain is an often overlooked factor in discussions regarding the descent of the profession.

Historically, normative physician identity in the United States was recognized as phenotypically white and strongly masculine in construction.[233] These characteristics facilitated a particular relationship to power, authority and expertise that was not readily accessible to foreign doctors with the same professional status. This chapter is argued using oral histories and published medical and sociological literature to analyze how foreign physician negotiated their care work and expertise within this professional framework. The first section provides a brief historical exploration of the relationship between masculinity, professionalism, and medicine, focusing on institutions and their significant role in shaping conceptions of expertise in the United States. I build on the work of scholars who have documented the relationship between gender and professions, marking a strong connection between embodied subjectivity and categories of laborers.

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[232] Eliot Friedson, "The Reorganization of the Medical Profession," *The Medical Care Review* 42(1985): 22.
[233] Robert Nye, "Medicine and Science as Masculine Fields of Honor," *Osiris*, 12(1997): 60-79.

The next section analyzes organized medicine's racialized and gendered critiques of foreign physicians' capability and performance in clinical practice. Organized medicine demarcated US medical graduates as fully possessing expertise and FMGs as lacking through subtle admonitions and negative characterizations. The final section explores the ways foreign physicians worked differently than their US educated counterparts to establish expertise and authority despite challenges they faced. FMGs developed techniques and strategies including extra time in the clinical encounter, extended work schedules, supportive relationships with peers, and extra medical and English language study to enact their expertise. The FMG case study responds to a recent call by historians of science and medicine to deconstruct and destabilize the monolith of masculinity ascribed to professional cultures.[234] By analyzing the nuances of masculinity and paying careful attention to how this construct intersects with race, this chapter shows how foreign physicians were denied access to hegemonic, masculine constructs[235] of physician expertise and the power associated with this social position.

Anti-colonial physician Frantz Fanon's *Black Skin, White Masks* heavily influences this chapter.[236] In this autobiographical as well as theoretical monograph, Fanon narrates the interaction of a white consulting physician with different patients in the clinic. "Twenty European patients come and go: 'Please have a seat. Now what's the trouble? What can I do for your today?' In comes a black man or an Arab: 'Sit down, old

[234] Erika Milam and Robert Nye, "An Introduction to Scientific Masculinities," *Osiris* 30(2015): 1-14.
[235] R. W. Connell and James Messerschmidt, "Hegemonic Masculinity: Rethinking the Concept," *Gender and* Society 19(2005): 829-859.
[236] Frantz Fanon was an anti-colonial, psychiatrist born in Martinique and trained in France. After he completed his training, he established a clinic in Blida, Algeria.

fellow. Not feeling well? Where's it hurting? You not good?'" Fanon presents this anecdote to draw attention to the relationship between language and the visual gaze, making apparent two important asymmetries. On one level, there is asymmetrical power in favor of the physician due to his professional role; and on another, there is a social distance indexed by the linguistic variability used to engage patients of different backgrounds. Fanon reflects on the linguistic shift writing, "We'll be told, there is no intention to willfully give offense…but it is precisely this absence of will…that is insulting." Even within this micro, intimate doctor-patient interaction, the historical and the political are ever present and structuring. This chapter inverts the relation Fanon describes to ask how a non-white, medical professional from a postcolonial nation is understood within a US clinical context. The clinical interaction stages a vulnerable confrontation of the most intimate kind, requiring a level of disclosure and trust that is usually withheld from strangers. In this space where matters of "birth, pain, and death" are negotiated, anxieties rooted in bodies and difference expectedly surface.

Consolidating Authority

In the early part of the twentieth century, historian Paul Starr marks an increase in professional status and authority of physicians in the United States. Prior to this, physicians operated as unsupervised, unregulated, solo practitioners with knowledge and training that was inconsistent across the profession. The nature of medical practice changed considerably due to progressive era reforms in medical education and licensing,

the rise of hospitals, an increase in specializations, and technological innovations.[237] These changes had the combined effect of producing an occupational closure,[238] organized medicine's deliberate attempt to consolidate a normative professional identity. The most effective closure strategy involved establishing and enforcing medical education and licensing laws. The AMA, the primary institutional actor representing organized medicine, persuaded state legislatures to deny licenses to practitioners without biomedical training and clinical experience. The action effectively removed alternative healers, such as homeopaths and hydropaths from the medical marketplace. The AMA continued to bolster physician power and status by reorganizing local medical communities into a broadly connected national network of physicians with a unified agenda and a cohesive social and political position.[239] Additionally, doctors shifted their physical site of work from a patient's home to a hospital setting and increasingly referred patients to specialists for treatments creating systematic dependency and reliance between medical practitioners in every day care.[240] In combination, these institutional changes removed competition from the medical market and produced a medical professional with standardized medical training, clinical abilities validated by a community of qualified

[237] James Burrow, *Organized Medicine in the Progressive E*ra, (Baltimore: Johns Hopkins Press, 1977).
[238] Anne Witz, "Patriarchy and Professions: The Gendered Politics of Occupational Closure," *Sociology*, 24(1990): 676.
[239] Paul Starr, "Medicine and the Waning of Professional Sovereignty," *Daedalus*, 107(1978): 180.
[240] Starr, "Medicine and the Waning of Professional Sovereignty," 181

peers, a higher earnings potential than ever before, and a cohesive public and political identity.[241]

Occupational closure was not only a practice for managing economic and professional aspects of medicine; it was also an exclusionary social strategy aimed at cultivating a particular physician image. Beginning in the mid nineteenth century, male identifying physicians used what Anna Witz refers to as "credentialist tactics" to mark a distinct gender boundary in the profession.[242] Through the manipulation of civil institutions such as medical education and accreditation, male physicians denied women entry into the profession creating a gendered monopoly well into the second half of the twentieth century.[243] Despite this strategic closure, a limited number of women managed to gain entry into the profession through individual accommodations and eventually, legal channels.[244]

In the streamlining of medical education and accreditation, male physicians elevated the status of physicians from an assortment of poorly trained, financially insecure practitioners into a cadre of elite, authoritative, educated professionals. This shift marked a change in the class status of physicians, which was maintained by limiting physician supply. In the first major attempt to control physician supply, the AMA organized medical professors from major universities into a Council on Medical

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[241] Paul Starr, *Social Transformation*, 14.
[242] Witz, "Patriarchy and Professions," 681. Also, see: Barbara Ehrenreich and Deirdre English, *Witches, Midwives, and Nurses: A History of Women Healers* (New York: CUNY Feminist Press, 2010).
[243] Stevens, *The Alien Doctor*, 19.
[244] Witz, "Patriarchy and Professions," 681-682.

Education.[245] This group called for an increase in the duration of medical school, and increase in the length of medical training and a license to practice.[246] If medical schools were unable to satisfy these requirements, states would no longer grant their graduates licenses to practice, ultimately making the medical school obsolete.[247] The increased years of education and training also required greater financial investment on the part of the medical institution, which was channeled into higher tuition and fees for students. This shift marked a change in the class status of entering medical students as the cost of attaining a medical degree increased significantly. Lower income students were unable to attend school due to the cost and because the increased length of education and training meant forgoing an income for a significant period of time. These financial constraints effectively turned medicine into an upper class professional endeavor.

The medical professions gendered and class image had an expected racial corollary: medicine was a white profession. Given the new educational reforms in the beginning of the twentieth century, only Howard and Meharry remained operational as schools for black medical students, enrolling 87% of the black medical students in the country.[248] Historian Kenneth Ludmerer noted that these institutions suffered severe financial obstacles. Because their student body was generally not wealthy, administrators were forced to keep tuition low to facilitate student enrollment. However, as tuition was a major source of revenue, Howard and Meharry were in a perpetual financial crisis. Black physicians encountered structural barriers in professional medicine even after completing

[245] Starr, *Social Transformation,* 117
[246] Ludmerer, *Time to Heal*, 5.
[247] Starr, *Social Transformation*, 119.
[248] Ludmerer, *Learning to Heal,* 52.

their medical education. In the early part of the twentieth century, there was an unofficial requirement that hospital staff should belong to a local medical society. By the 1930s, the AMA formalized this requirement by withholding accreditation for internship training from hospitals without the full participation of staff members in local medical societies. However, it was impossible for black doctors to satisfy this requirement since they were racially excluded from local societies. The result of these covert discriminatory practices forced black doctors to settle for privileges at less prestigious, under resourced hospitals with few opportunities to advance their medical careers.[249] The frustrations with these practices was exemplified in the case of ten black Chicago physicians who filed a lawsuit on February 10, 1961 "on behalf of all Negro physicians in Chicago" with "the object of gaining admission to hospital staffs."[250] Their grievance was against five medical associations and 56 hospitals in the Cook County area, alleging "hospitals and corporations continued to maintain arbitrary restrictions and limitations against the admission of Negros as patients and against the appointment of Negro physicians to medical staffs…and that these practices constitute a monopoly of the business."[251]

In tandem, these occupational closures cohered an identity of a physician as a male, white, upper class professional with considerable prestige and cultural authority. These characteristics further amplified the masculine honor codes, which historian Robert Nye suggests were embedded in medicine's professional culture for over two hundred

[249] Max Seham, *Blacks and American Medical Care*, (Minneapolis: University of Minnesota, 1973), 72-73.
[250] "Chicago Physicians Sue For Admission to Hospital Staffs," *Journal of the National Medical Association* 53(1961): 198.
[251] "Chicago Physicians Sue For Admission to Hospital Staffs," *Journal of the National Medical Association* 53(1961): 199.

years. Although Nye's study is primarily based in a Western European context, the conclusions are extended across the Atlantic. Nye argues that overt mechanisms of occupational closure like the ones mentioned above were coupled with informal strategies to produce a "masculinization" of professional culture that was aimed at "admitting and retaining only a *certain kind of man* [emphasis original]."[252] The most important qualities embodied in professional masculine sociality were independence, assertiveness, truculence, and bravery.[253] This sociality was undergirded with a capacity and demand for violence if an individual violated the norms or was inattentive to the structuring logics of the gendered scripts.[254] Sociologist R.W. Connell argues over time, while the demand for violence still persisted, it was sublimated for a gentler masculinity, "organized around themes of rationality, calculation, and orderliness."[255]

These became the recognizable traits of a *certain kind of* masculine professional in scientific and medical communities across Europe and the United States. Men of science reoriented the natural world in a rational, recognizable, and predictable fashion as exemplified by Foucault's insights about the medical gaze in *The Birth of the Clinic*. He argues that a new discursive, structuring praxis emerged in the modern era elevating physician status in society.[256] This "episteme" ushered in a way of seeing and speaking of health and illness, which was fundamentally dependent on the site of the hospital.[257] For

[252] Nye, "Medicine and Science as Masculine Fields of Honor," 71-72.
[253] Nye, "Medicine and Science as Masculine Fields of Honor," 61.
[254] Nye, "Medicine and Science as Masculine Fields of Honor," 72.
[255] R.W. Connell, "The State, Gender, and Sexual Politics," *Theory and Society*, 19(1990): 521-522.
[256] Foucault, *Birth of the Clinic*, 33.
[257] Foucault, *Birth of the Clinic*, 25-26, 28.

the first time, physicians had access to sizable patient populations allowing doctors to observe large amounts of data about the signs and symptoms of specific illnesses and classify that information into categories of normal or pathological.[258] This restructured way of seeing illness supplanted the older understandings of the body as a whole unit and ushered in a new way of practicing medicine grounded in anatomy and dissection. These methods resulted in a new conceptual language that ordered the messiness of sickness into predictable, identifiable categories of thought and perception. It was a discursive and statistical mastery over nature that gave doctors new predictive powers in terms of population health making them integral for modern, liberal governance practices.[259]

The medical profession continued along an ascendant trajectory until approximately the mid twentieth century. Gallup polls from the 1930s well into the 1950s reported that the public viewed physicians amongst the most highly admired members of society.[260] The consolidation of the profession in addition to technical, scientific, and surgical advances during this period instilled public confidence in these practitioners. Penicillin's discovery and a successful polio vaccine were examples of highly celebrated achievements that convinced the public of the therapeutic possibility of science and medicine. This triumphalist orientation imbued the medical profession with a newfound cultural authority based on these displays of expertise. As medical information and

[258] See also Georges Canguilhem, "The Normal and the Pathological" in *Knowledge of Life* (New York: Fordham Press, 1952), 121-134.
[259] Ian Hacking has written extensively on this. See: Ian Hacking, "Biopower and the Avalanche of Printed Numbers," *Humanities in Society* 5(1982): 279-295; "The Autonomy of Statistical Law," in *Scientific Explanation and Understanding* ed. N. Rescher (Pittsburgh, 1983). Also, Theodore Porter, *Trust in Numbers* (Princeton: Princeton University Press, 1996).
[260] John Burnham, "American Medicine's Golden Age," 1474.

scientific research became more technical and a prominent aspect of medical care, the informational asymmetry between doctors and patients grew. This chasm resulted in patients relinquishing power in the clinical interaction and relying more readily on their physician's authority and expertise.

In *The Social Transformation of American Medicine*, Paul Starr defines authority as "the possession of some status, quality, or claim that compels trust or obedience" and those who possess authority persuade the public through legitimacy and dependency.[261] Medical men commanded authority not only by virtue of their mastery over nature and biology, but also by their ability to convince others of this knowledge. Thus, performance of expertise, persuasion of this quality, was a necessary corollary to knowing medical facts. Expertise is embedded in networks of interactions between producers of this quality and consumers of its performance. It is a perpetual process of becoming that must be reenacted in every interaction.[262] Steven Shapin and Christopher Lawrence articulated a similar argument concerning performativity relating it explicitly to the embodiment of scientific practice. They explain: "questions about the status and worth of knowledge have been partially dealt with by bodily presentations of those who produce and report on that knowledge…[scientific] truth may be conceived as a personal performance, an individual act that uses culturally given materials for its point and value."[263] While physicians become institutional experts through documents, their expertise is continually

[261] Paul Starr, *Social Transformation*, 9.
[262] E. Summerson Carr, "Enactments of Expertise," *Annual Review of Anthropology* 39(2010): 19.
[263] Steven Shapin and Christopher Lawrence, "Introduction: The Body of Knowledge," in *Science Incarnate: Historical Embodiments of Natural Knowledge,* (Chicago: University of Chicago Press), 10.

subject to evaluation by peers and patients through social interactions. As such, a physician relies heavily on a linguistic repertoire, speech delivery, and a corporeal style to convince their audience of their expertise and maintain this status. Those who can deliver the most commanding performance are understood to embody the greatest level of expertise.[264;265] E. Summerson Carr emphasizes this point explaining that becoming an expert "can hinge on casting other people as less aware, knowing, or knowledgeable. Indeed, expertise emerges in the hoary intersection of claims about types of people, and the relative knowledge they contain and control."[266] In the process of differentiating expertise, entrenched social hierarchies were grafted to questions of a medical practitioner's quality, authenticity, and professionalism. And in this evaluation, the US educated, white, masculine doctor was conferred the highest status. In 1961, Howard Becker et al., published *Boys in White*, a study of "boys becoming medical men."[267] They explained that although women were present in the clinical space, the medical profession was "overwhelmingly men…and the majority of students are native-born and white."[268] Becker concludes that the "students are quite homogenous in their present and will be more so in their future, social class affiliations."[269]

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[264] AV Cicourel, "Language and Structure of Belief in Medical Education," *Studies in Linguistics* 35(1981*):* 71-85.
[265] Judith Butler, *Gender Trouble: Feminism and the Subversion of Identity* (New York: Routledge, 2006), 139.
[266] Carr, "Enactments of Expertise," 22.
[267] Howard Becker, et al., *Boys in White: Student Culture in Medicine* (Transaction Publisher, 1976), 3
[268] Howard Becker et al., *Boys in White*, 60.
[269] Howard Becker et at., *Boys in White*, 60.

As these boys became medical men, they were trained to perform a particular version of expertise with a masculine character. Judith Butler, in writing about the relationship between gender and performance explaining that gender is not fixed or a given category. It is "tenuously constituted in time, instituted in an exterior space through a stylized repetition of acts."[270] Butler identifies movements, gestures, phrases and practices as the acts that are repeated tethering an individual to a particular gendered praxis. For US trained physicians, the medical educational setting became an important site to acquire this gendered praxis through an informal education on language, comportment, and forms of sociality embedded in physician identity. This training was meant to create an additional level of homogeneity in the profession by instilling in students the "attitudes and values in keeping with the role of the physician."[271]

In 1957, Robert Merton edited a collection of essays entitled *The Student-Physician*. In this volume, three contributors analyzed various aspects of the sociology of medical education and its relationship to the "processes of attitudinal learning." The first piece by Mary Huntington, "The Development of a Professional Self-Image," shows that medical students saw themselves in the role of doctor in relation to their patients early in their medical schooling, well before they completed the degree. This was especially apparent in interactions between high needs patients and medical student. These interactions allowed students to imagine themselves as action oriented, problem-solving

[270] Judith Butler, *Gender Trouble*, 140.
[271] Mary Jean Huntington, "The Development of a Professional Self-Image," in *The Student-Physician* ed. Robert Merton (Cambridge: Harvard University Press, 1957), 177.

physicians who successfully performed their role as physicians.[272] These findings were corroborated in William Martin's study, "Preferences for Types of Patients." Martin finds that medical students who self-judged their performance favorably in clinical interactions held a neutral attitude towards patients. In other words, medical students who felt confident in their ability to control a situation and successfully act out the role of doctor were indiscriminate towards difficult or irritating patients. The confidence in their technical skill set had the effect of negating the patient's presence and provided a theatre for the doctor's performance.[273] Renee Fox authored the final piece in the section titled "Training for Uncertainty." Fox identifies three forms of uncertainty: the first is the result of the student's incomplete mastery over content, the second is the uncertainty related to the state of medical knowledge and the third consists of the uncertainty of "distinguishing between personal ignorance or ineptitude and the limitations of present medical knowledge."[274] As a student moves further along in his medical education, expectedly, his uncertainty with his own skill and knowledge decrease and feelings of uncertainty are redirected towards the state of medical knowledge.[275] Taken together, these three studies highlight important character traits and qualities integrated into standard medical learning.[276] Doctors were trained to be confident, decisive practitioners who should effectively command and control a situation, irrespective of the difficulty of the case, their lack of knowledge or the behavior of the patient.

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[272] Mary Jean Huntington, "The Development of a Professional Self-Image," 179-187.
[273] William Martin, "Preferences for Types of Patients," in *The Student-Physician* ed. Robert Merton (Cambridge: Harvard University Press, 1957), 189-205.
[274] Renee C. Fox, "Training for Uncertainty," in *The Student-Physician* ed. Robert Merton (Cambridge: Harvard University Press, 1957), 209.
[275] Renee C. Fox, "Training for Uncertainty," 207-241.
[276] All of the studies used the pronoun he when describing physicians.

Until the mid-twentieth century, organized medicine's efforts to cohere the medical profession and create homogeneity were largely successful. However, the crisis in physician manpower and legislators' use of the 1965 Hart-Celler Immigration and Nationality Act to ameliorate the situation suddenly disrupted normative physician identity. Between 1963 and 1971, more than one fifth of practicing physicians and one-third of physicians in graduate training, as interns or residents, were foreign born men.[277] The gendered nature of elite migration during this time was very different than the gendered ratio for unskilled workers, which favored women Skilled laborers, especially physicians and scientists from South Asia, were heavily skewed in favor of men, reflecting schooling and training opportunities afforded to men in country of origin. These gendered social possibilities were not unique to Asian countries. They reflect what theorist R. Connell describes as the gendered world order, a system of organizing gender arising out of colonial contexts that continues to inform structures into the present. Connell argues that the export of European institutions created specific patterns of practice, patterns of rule following, and domination.[278] These gendered, and more specifically, hegemonically masculine ways of being were embedded in institutional logics and created a global standard for masculinity.[279] Medicine was a part of this gendered regime of transnational institutions. While local contexts certainly shaped and modified the institution, the foundational character was never lost. This "*globalizing masculinity"* (emphasis in original), as Connell terms it, has become standardized across

[277] Stevens et al., The *Alien Doctor,* 1; James Huag and Rosemary Stevens, "Foreign Medical Graduates in the United States in 1963 and 1971: A Cohort Study," *Inquiry* 10(1973): 26.
[278] R. W. Connell, "Masculinities and Globalization," *Men and Masculinities,* 1(1998): 9-11.
[279] R. W. Connell, "Masculinities and Globalization," 11.

localities.[280] However, as in the case of FMGs in the United States, the effort to standardize masculinity highlights important tensions related to how gender articulates with other modes of identity and which bodies are allowed to access dominant gender performances in the medical institution.

FMGs Enter Clinical Practice

Foreign physicians were undeniably different than their US counterparts. They entered a professional space hostile to their presence, yet in desperate need of their labor. Dr. A, a Pakistani physician educated in Karachi remarked on this saying, "[they] looked down on us but without us, you can't run the system."[281] These physicians became integral to the "system" beginning with the Hart-Celler Act and continued until today. FMGs' subject position in the United States reflected the complexities in the concept of inclusion. They were legally included allowed to traverse the physical border of the nation-state by virtue of their labor market position. However, this inclusion was subjected to varying degrees of fragmentation, contingency, and accessibility in social and political spaces. FMGs arriving to the United States for the first time in the 1960s were confronted with their contradictory subject position most prominently in clinical practice. The medical establishment, which cohered a specific corporeal and attitudinal identity over time, reluctantly included FMGs amidst their ranks. In published studies on FMG performance, the hesitations emerge as racialized and gendered critiques casting doubt on foreign physicians' clinical expertise.

[280] R. W. Connell, "Masculinities and Globalization," 12.
[281] Dr. AA, interview with author, Illinois July 23, 2015.

In 1969, Harold Margulies and Lucille Bloch published a study on the characteristics of a Foreign Medical Graduate. Below is a lengthy description of their data and personal observations:

> The FMG is an unmarried male from either Asia or Latin America…He was [sic] recently graduated from a government supported and operated medical school which has a five year course of study, a skimpy budget, and a part-time faculty. He came from a lower middle class family, which has no savings and relatively little education. He learned English as a second language taught him by instructors for whom it was also a second language…His education was highly authoritarian and was occasionally interrupted by student strikes. He has taken many examinations, but the ECFMG was the first one that was both objective and comprehensive. He passed it with a minimum passing grade on the second try. His position at the hospital made him extremely anxious until he discovered that only rarely did anyone seem to read his histories or physical-examination notes. He quickly learned a core of routine procedures that each of the staff physicians wanted performed.[282]

In the quoted passage, Margulies and Bloch describe a FMG in terms that contradict the image of US medical graduates. Most obviously, the practitioner is non-white and from a low socioeconomic class. Attention to these characteristics deliberately highlights racial and demographic difference and incommensurability between foreign and US physicians, further emphasized by the family's lack of education. As a consequence of the family's socioeconomic position, the FMG attended a medical school of suspect quality, both in terms of educational resources and pedagogical style. By referencing an authoritarian style of learning and student strikes, Margulies and Bloch inflect FMGs' medical education with a crude interpretation of postcolonial spaces and their possibility for harboring totalitarian threat. With this observation, they not only question the quality of the medical education FMGs' received, they also subtly raise doubts about the political

[282] Howard Margulies and Lucille Bloch, *Foreign Medical Graduates in the United States* (Cambridge: Harvard University Press: 1969), 5-6.

leanings of the Asian and Latin American doctors and their viability in a democratic space.

To further discredit a FMGs' educational qualifications, the authors disparage exams administered in the country of origin thereby negating the education received in these settings. In their estimation, the ECFMG, as a stand in for US medical training, was the only respectable assessment of a foreign physician's knowledge and abilities. And as mentioned in the previous chapter, even this exam was discredited at times with arguments that anyone could study and pass a test of basic scientific and medical facts. This alone did not qualify a FMG for medical practice; it was not the sole basis of expertise. Margulies and Bloch's mention of the part-time faculty and the useless examinations in FMGs' medical training highlight an often repeated concern by organized medicine: the possession of credentials was not a good criterion for measuring expertise. Expertise was a quality or performance that was local in character and operated in a field refereed by other practitioners entrenched in the same social values and community. FMGs were ostensibly outside of this frame due to their training elsewhere and posed a peculiar problem to the medical establishment. Expertise becomes more "what you can do rather than what you can calculate or learn."[283] In *Rethinking Expertise*, Harry Collins and Robert Evans provide a schematic for expertise consisting of five levels: novice, advanced beginner, competence, proficiency, and expert. Once someone reaches the fifth level of expertise, as a medical profession is presumed to have done, they achieve expert status incorporating all lower levels. Skills and knowledge are so

[283] Harry Collins and Robert Evans, *Rethinking Expertise*, (Chicago: University of Chicago Press, 2009), 23.

thoroughly internalized and embodied in the full expert that they are able to perform required tasks seamlessly and efficiently.[284] Furthermore, their expert status is publically acknowledged through credentials, documents embedded with the implicit assumptions of a level of expertise.

A foundational component of the ability "to do" that Collins and Evans referred to was speaking a specialist language and access to a linguistic community. A foreign physician could perform fluency in technical information such as disease prevalence and prognosis, but this linguistic mastery was divorced from the concomitant enculturation in the form of life due to their non-US based training. When Margulies and Bloch commented on the English abilities of their prototypical FMG, "he learned English as a second language taught him by instructors for whom it was also a second language," they distanced a FMG from full acceptance into the cultural world of US medicine and its possibility for a particular kind of embodied expertise. The emphasis on the degrees of separation from "proper" English is another way of accentuating their distance from the normative constructions of a physician. Collins and Evans explain, "The nature of a whole language is a function of the whole environment, physical and social, in which it develops. Change the environment (e.g., remove the physical activity which is initially an integral part of the development of a language), and the language will change."[285]

These observations echo Frantz Fanon's discussion of the relationship of language to colonial domination in *Black Skin, White Masks*. Language imbues meaning in those who embody it and as the language user performs linguistic mastery, they are

[284] Collins and Evans, *Rethinking Expertise*, 24-45.
[285] Collins and Evans, *Rethinking Expertise,* 35.

transformed in the process. Fanon argues that language for a colonized person was a means to appropriate the colonizers, or white, world.[286] When a non-white individual masters a language and puts "himself on equal footing," possibly becoming "a pure replica of the white man," this raises serious concerns for the dominating group. If a non-white speaker exhibits this mastery, the response by the dominating group is often a denigration of the efforts and skills of the non-white individual.[287] Thus, language has the effect of circumscribing and demarcating a way of being for its users. In this capacity, both the technical language of medicine and the English language more broadly, operated as gatekeepers for the medical profession. Although FMGs attempted to mimic the "cultural tool of language" as Fanon calls it, their mimesis was imperfect and understood to be inauthentic, thereby making their foreign doctoring questionable.

Organized medicine frequently raised doubts related to FMG medical performance and substandard language fluency. In a paper entitled "The Changing Supply of Physicians in California, Illinois, and Ohio" and submitted to the U.S. House in 1974, Pierre De Vise wrote:

> Physicians graduated abroad are generally regarded as less competent than U.S. and Canadian trained physicians. Foreign Medical Graduates tend to gravitate to practices in large urban areas that have little attraction for U.S. graduates. Concentrations of Spanish-speaking and Medicaid populations are strong attractions for FMGs because fluency in English is less at a premium for this clientele. Thus, high proportions of FMGs are found in Queens (34%), Brooklyn (31%), Richmond (30%) and the Bronx (20%). The lowest proportions are found in metropolitan Upstate and nonmetropolitan Upstate.[288]

In this statement, the competency of the physician is directly connected to language

[286] Fanon, *Black Skin, White Masks*, 19.
[287] Frantz, *Black Skin, White Masks,* 19.
[288] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 468.

fluency and quality of care. De Vise's argument is as follows: FMGs are inadequate practitioners in comparison to US contemporaries and are fully cognizant of this fact. As a result, they work in non-white, impoverished communities where there is little expectation for high quality of care. In De Vises's analysis, the structural conditions that dictated the placement of FMGs in underserved areas are ignored for a linguistic explanation of work placement in shortage area communities. De Vise articulates a political economy of linguistic practices in medical care where those with less linguistic and financial resources are treated by "less competent" physicians.

Language operates as a proxy for medical expertise and legitimacy and those language users with a different relationship to US spoken English are perceived as questionable doctors.[289] In De Vise's critique of language, there is an implicit condemnation of the environment or world that produced the speaker. Language operates as an identifiable, outward culmination of a cultural world. It represents a social valuation, where "the personae indexed by language are not value neutral, but stratified, so that some varieties and their uses are positioned as "correct," "good" and "normal," and others are not."[290] Linguistic fluency positioned FMGs as inferior to their US English-speaking colleagues. Thus, the stratified care that De Vise referenced fits within this hierarchical, discriminatory understanding. Those who are unable to speak the language well should provide medical care to individuals who are "Spanish-speaking and Medicaid" users because these patients fall lower on the social order than the Upstate

[289] Because the majority of South Asian FMGs were educated in English medium institutions, they spoke British English.
[290] Hilary Dick, "Language and Migration to the United States," *Annual Review of Anthropology,* 40(2011): 228.

New York clientele for whom English is more "at a premium." While language fluency was undoubtedly necessary for communicating and operating in the US medical sphere, De Vise's observations illuminate one specific way that a two-tier system of healthcare was justified and sustained in the United States.

Organized medicine's hesitations about FMG linguistic limitations were brought to the fore most prominently in relation to psychiatric practice. In a paper published in the *American Journal of Psychiatry* in 1973, two physicians, E. Fuller Torrey and Robert Taylor described the problem. They reported that in 1970, 34% of all psychiatry residents were FMGs and of the 186 residency programs in the country, 28 were completely filled by foreigners. These physicians are "found in large numbers in city and state hospitals, prison hospitals, and institutions for the mentally retarded…Because of their concentration in public institutions, patients who cannot afford private psychiatric care are more likely to be treated by foreign-trained physicians."[291] The numbers of FMGs staffing public hospitals was staggering. In New York, the authors reported that 198/211 or 94% of psychiatry residencies were filled by FMGs. Although the percentage in New York was the greatest, the percentages along the east coast were never below 77%.[292] Torrey and Taylor explain their concern with psychiatric care below:

> Psychiatry, in contrast to radiology or pathology, is the medical specialty in which communication between the doctor and the patient is absolutely essential for diagnosis and treatment. Equally important are possible cultural differences and the lack of a similar worldview between doctor and patient. Imagine the difficulty, for instance, of a psychiatric resident from Korea trying to assess the mental problems of a drug-abusing adolescent who is undergoing an existential crisis.[293]

[291] E. Fuller Torrey and Robert Taylor, "Cheap Labor From Poor Nations," *American Journal of Psychiatry* 130(1973): 734.
[292] Torrey and Taylor, "Cheap Labor From Poor Nations," 735.
[293] Torrey and Taylor, "Cheap Labor From Poor Nations," 735.

The connection between quality of care, language, and the social location of patients is made explicit in these statements and once again emphasizes the political economy embedded in linguistic practices. The medical community used those they considered less qualified physicians to provide significant services to populations with less social and economic capital, users of public medical care. The stratified system of health access is mediated through a sociolinguistic register. In referencing the mismatch between the Korean psychiatrist and the adolescent undergoing an existential crisis, Torrey and Taylor marked an incompatibility between the social, cultural, and psychic worlds of the doctor and the patient, respectively, and measured this disconnect through language fluency. They suggested that the FMG was unable to draw upon linguistic resources to provide effective, expert level care.

Linguistic capability and performance has long operated as a boundary for immigrant communities in the United States and was readily deployed during Congressional hearings on Health Manpower in 1974. Robert Derbyshire, an important figure in medical licensing testified before Congress claiming that this issue was so problematic because there were no adequate ways to evaluate English aptitude necessary for patient care. He discredited the ECFMG English exam component saying, "after one has tried to converse with many foreign physicians who, according to the ECFMG, have demonstrated proficiency in the English language, one wonders what kind of test they were given."[294] In reality, as the case of the psychiatrists' shows, verbal aptitude was a stand-in for concerns about levels of US enculturation and the incongruity between a

[294] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 773.

non-US physician and their American patients and colleagues. Dr. Robert Weiss from the Center for Community Health and Medical Care at Harvard University stated during the hearing, "I think it is quite apparent that one of the most important things in any phase of medicine, in any kind of practice, is the taking of an adequate history, and how people who have been readily trained, not just in language, but in culture and mores, it becomes more difficult to deliver quality care."[295] Dr. Thomas Piemme of the George Washington University Medical Center shared this view, adding, "with respect to the foreign medical graduates, they ought to have not only competence in the English language both verbal and written, but a knowledge of the spectrum of American culture." For example, Piemme said, "the view of women that some persons immigrating to this country practicing medicine have is substantially different from those of our own."[296] Not only do these characterizations render FMGs as unskilled practitioners, they also manage to reify an authentic, Enlightened, American culture with an ontological existence that is coterminous in US born individuals. There is fixity to this imagined community and as a result, the immigrant physician is located on the outside. This is evident in Piemme's example of the mismatch concerning "the view of women," a comment reflecting easily accessible Orientalist imaginary and ready tropes of repressive masculinity.[297] English became a way to question the compatibility of FMGs within the US medical system. They could immerse themselves in technical biomedical discourse about disease

[295] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 748.
[296] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 779
[297] See, Edward Said, *Orientalism* (New York: Vintage Books, 1979); Puar, *Terrorist Assemblages*.

prevalence and prognosis, but their lack of enculturation in the form of life meant that they were always just slightly outside of the normative constructs. A questionable medical education in an unstable political environment, poor communication skills, and underwhelming exam performance, rendered a FMG subpar in comparison to a US medical graduate.

Margulies and Bloch end their long descriptor of a FMG with the following lines: "His position at the hospital made him extremely anxious until he discovered that only rarely did anyone seem to read his histories or physical-examination notes. He quickly learned a core of routine procedures that each of the staff physicians wanted performed." This assessment of the poorly educated Other established a hierarchical relationship to knowledge and authority. Implicit in these conclusions is a valuation of a FMGs ability and trustworthiness to effectively doctor. When describing the clinical performance of a foreign doctor, Margulies and Bloch's attribution of anxiety and a desire for routine remove foreign physicians from masculine characteristics by invoking an affective relationship to medical practice and placing FMGs in a submissive role; they were anxious followers. They were not rational, action-oriented leaders. There was an symbolic enacted on FMGs through these characterizations. As Pierre Bourdieu writes, "The effect of symbolic domination (whether ethnic, gender, cultural or linguistic) is exerted not in pure logic of knowing consciousness but through the schemes of perception, appreciation, and action that are constitutive of habitus."[298] Using this analytic, it is possible to identify the subconscious, hegemonic structures of value that

[298] Pierre Bourdieu, *Masculine Domination,* trans. Richard Nice (Stanford: Stanford University Press, 2002), 37.

Margulies and Bloch used to judge FMG inferiority. Their racialized and gendered critiques, widely shared by others in the medical community, suggest that FMGs are incapable of fully embodying expertise because the conditions of their making precluded this possibility.

In the late 1960s, the impact and quality of FMGs on the US medical system was still an unknown. Heightened interest in this question led to numerous articles published on the topic. In 1967, Margulies and Bloch produced another study for the Association of American Medical Colleges and the National Advisory Commission on Health Manpower on the professionalism of FMGs and their conclusions were corroborated in the findings of Jacob Halberstam et al. who published three articles on FMG performance. These studies assessed FMG professional competence as evaluated by members of the hospital teaching staff. The evaluators assessed roughly fifteen criteria:

> (1) acclimatization to new environments and duties; (2) ability to accept discipline; (3) competence in general house officer's duties; (4) ability to take a medical history; (5) ability to perform a physician examination; (6) knowledge of basic medical science; (7) quality of relations with patients; (8) character of personal relations in hospital; (9) character of professional relations with staff in hospital; (10) skill in the use of libraries; (11) need for supervision in patient care; (12) rate of learning; (13) effect on teaching functions of staff; (14) capacity for independent leaning; (15) fitness for medical practice in the local community.[299]

Overwhelmingly, and perhaps unsurprisingly, the results showed that FMGs underperformed in relation to their US counterparts in all categories. While the authors of the studies noted that a significant barrier for FMGs was the structure of medical training in the United States, their data certainly raised questions regarding FMG capability and demarcated FMGs from their US contemporaries. The US cohort performed leadership,

[299] Margulies and Bloch, *Foreign Medical* Graduates, 49-52.

independence, confidence, and assertiveness – the masculinized qualities of medical professionals – and foreign doctors were judged as less than in comparison. They failed to perform the qualities Robert Nye identified in the right kind of masculine, medical professional. Foreign doctors lacked independence, assertiveness, truculence, and bravery.[300]

An important aspect of the structures of medical training that Margulies and Bloch referred to was the informal sociality built into medical education through interactions in the clinical setting. FMGs did not have access to this implicit knowledge regarding comportment, language, and non-verbal communication learned early on in medical training. In 1975, Eliot Friedson published a study of doctors, noting when it came to the core of medical performance, there were unwritten ways of enacting "good practice." These behavioral norms where not articulated explicitly, although Friedson argued that there existed a consensus regarding what good practice looked like. He stated that medical professionals assumed "if a physician was hired with a bona fide license and with the residency and practice experience," this person would know how to doctor.[301] However, this assessment simplified and flattened the importance of medical socialization. The way of thinking and acting like a physician was irreducible to knowledge of basic science information and disease processes.[302] Renee Fox's study "Training for Uncertainty" referenced earlier illustrates the importance of sociality in medical practice. In her work, she analyzed the way medical students negotiated their relationship with uncertainty over the course of their medical education. When a student

[300] Nye, "Medicine and Science," 61.
[301] Friedson, "The Reorganization of the Medical Profession," 33.
[302] Fox, "Training for Uncertainty," 223.

enters the third year of medical school, they are introduced to the clinical space and interact with clinical faculty in formative ways. Fox narrated the response of one of her medical school informants, writing:

> Meeting with members of the faculty or the house staff in small intimate groups and discussing patients with them is 'the heart of clinical medical education…Sessions like these 'give insight into how a doctor organizes and uses his information and a real sense of colleagueship. You catch the feeling you must have in a craft: the father passing the secrets of the craft on to the son.'…He also adopts a manner of certitude for he has come to realize that it may be important for him to 'act like a savant' even when he does not actually feel sure.[303]

The medical student's reference to a craft and a father and son relationship highlights the apprenticeship structure of medical training and the importance of non-textbook based learning for developing the skills and abilities to doctor effectively and in accordance with the particular way of being a doctor in the United States. By watching, conversing with, and proximity to senior practitioners, students were made into colleagues and taught how to behave in ways that projected authority and confidence. These informal methods of initiation in the medical profession based on observation and mimesis subtly distanced FMGs from mainstream medical cultural life. Dr. B, a physician from Pakistan commented on these "small differences in language and culture." He recounted an experience from his first year as a resident:

> When I came I was shocked when I saw that my colleagues and fellow resident, they way they were talking to the [seniors]. Over there, we had a very different kind of a culture. You couldn't even ask your senior professors questions. Over here, I arrived on the first day and our program director came to the resident conference and the residents were eating and putting their feet up on chairs and I stood up when the director walked in [out of respect]. And the [other residents] were saying 'what is wrong with him?'"

[303] Fox, "Training for Uncertainty," 227-228.

Dr. B was trained in a medical cultural system where a particular form of deference and hierarchy for senior physicians was practiced. This clashed with ”colleagueship” that the third year medical student quoted above experienced with his attending physician. Dr. B’s more formal orientation and interactions with his seniors located him outside of the informal, social practices that marked inclusion, belonging, and familiarity in the clinical setting. Perhaps the observation that Margulies and Bloch made in the beginning of this section, “he quickly learned a core of routine procedures that each of the staff physicians wanted performed,” should not have been interpreted as an indictment of a FMG’s clinical skill, but rather indicative of his training in a medical culture that operated with different cultural logics and hierarchies. Cultural dissimilarities were additionally exacerbated by logistical realities. Many FMGs lived on the hospital site where they were offered housing, while their US colleagues, if there were any at the hospital, lived elsewhere due to their increased familiarity with the area or access to transportation. The accumulation of these small differences resulted in a degree of social separation between foreign physicians and their US colleagues.

In response, FMGs developed forms of sociality and community amongst themselves, creating networks of support, both personally and professionally. Dr. A, a Pakistani physician working in a major public hospital, recalls the unexpected solidarity he developed with his fellow Indian physician. He was surprised by this shift in his thinking due to the historic and ongoing tensions between the two countries. Dr. A recalled Indians being discussed in “a certain way [in Pakistan] and taught certain things [about them],” but in the context of a residency cohort, “you had to be open-minded.” He

attributed similar social habits, such as refraining from alcohol consumption and a shared orientation towards sexual relations, as points of commonality that allowed an organic camaraderie to emerge. This feeling of camaraderie amongst FMGs extended into the clinical space as well. A Pakistani physician, who had excellent English language skills due to the British influence on the South Asian educational system, noted the importance of the relationship he developed with a Peruvian FMG. This individual was an "excellent clinician" but lacked English proficiency. The two developed an "alliance"; the Pakistani doctor helping the Peruvian physician with his English comprehension and the Peruvian FMG assisting the Pakistani doctor in his clinical work.[304] While developing networks of support and collegiality are to be expected, the divisions between FMGs and their US counterparts in this regard are noteworthy and at times made it difficult for FMGs to gain the cultural competency they were accused of lacking.

FMGs Perform Expertise and Authority

FMGs presented a dilemma to the medical community. Their services were procured to bolster the mismanaged medical system, yet their physical presence disrupted the very system they were invited to join. Patients, who were socialized to expect a particular physician image, also felt the dissonance and contradictions between norms embedded in the medical system and the presence of a foreigner in the role of a physician. Dr. N, an Indian male physician working in a large Washington DC public hospital recalled patient interactions early on in his career vividly: "Some white patients would say if I wanted to change something that I had to ask the main doctors before I

[304] Dr. AA, interview with author, Illinois, July 23, 2015.

changed anything. [Another patient] said you come from the cobra snake charmers land, do you know much of medicine? This patient was a black guy and a druggie and a freebie patient and he said your culture is all cows and snake charmers."[305] Dr. N's remarks are illustrative of his positionality within the medical system. The demand that he consult with the "main doctor," which usually signified the white, male, attending physician, indexed his incongruence with the patient's image of a physician. For white patients, an Indian physician's authority and expertise was uncertain and produced anxieties and doubt about capabilities. Dr. N's remarks echo the experience Frantz Fanon had while providing medical care. Referring to himself in third person, Fanon wrote, "I knew that for instance if the physician made one false move, it was over for him and for all those who came after him…As long as everything was going smoothly, he was praised to the heavens; but watch out – there was no room whatsoever for any mistake. The black physician will never know how close he is to being discredited."[306] In this quote, Fanon articulated his vulnerability and subject position within the medical system; he operated with trepidation knowing that his place in the system was permanently tenuous.

Dr. N's characterizations of his "black", "druggie and freebie" patient also socially located him in a position that is superior to his patient. His irritation with the suggestion that he was unqualified indexed the patient's transgression of the social order. This particular patient was not granted the right to question. In these moments of uncertainty, all parties involved reverted to stereotypical scripts to situate the scenario within more familiar frames. They became an "image in the third person" to one another,

[305] Dr. Navin Shah, interview with author, Potomac, MD, June 14, 2015.
[306] Fanon, *Black Skin, White Mask*, 97.

abstracted constructs devoid of substance.[307] The disparaging remarks, both made and received by Dr. N, demonstrate an important dimension of patient care that was frequently articulated in oral histories. Foreign physicians recalled operating differently than their US colleagues to establish trust and confidence in the clinical interaction. They were denied access to the expertise and authority inhered in the cultural identity of an American physician and developed techniques to negotiate this differential.

Many FMGs reported arriving in the United States for the first time with limited financial resources and a scattered group of acquaintances. Dr. AA arrived in Chicago in the winter of 1968 and was a resident at Cook County hospital, one of the largest public hospitals in the country. His impressions upon arrival convey a sense of the transition he experienced:

> I had no understanding of where I arrived. When I came to [Cook] County, I couldn't believe I was in America. All I saw were black people. The area around the hospital was not developed. There were a lot of burned out houses because that was the time MLK was assassinated and there was a lot of rioting. For a while I was shocked, I wondered where I was. It was a very difficult adjustment period for me.[308]

Because foreign physicians transitioned to the United States during a time of intense social and political negotiation, they had to contend with an image of America that was not the one in "movies or shows." This America only recently enforced desegregated medical spaces, had an abundance of poverty, and an inequitable distribution of resources. This was the America where all Dr. AA "saw were black people," contrary to the representations of America disseminated in Cold War propaganda. In these spaces of care, foreign physicians had to quickly gain political awareness while simultaneously

[307] Fanon, *Black Skin, White Mask*, 90.
[308] Dr. AA, interview with author, Illinois, July 23, 2015.

adjusting to linguistic differences, unfamiliar medical equipment and procedures, and a generally American way of doctoring.

In interviews, FMGs repeatedly reported using extra time as their primary method of establishing their presence in the clinical encounter. Dr. IB, a Pakistani physician working at a community hospital in Chicago reported on how he navigated interactions with his emergency room patients differently than his predominately white, male attending physicians. When he began working in the early 1980s, he remarked that the patients could sense his discomfort, "and it was a big struggle to present yourself in a way that yes, you were a doctor."[309] In order to instill confidence, Dr. IB explained his method:

> I really used to do [my] homework. Whenever I would get a call from the ER, I would read about the patient before I went there. I felt that the patient would feel very comfortable when I knew a few things before hand…I learned that most of the questions the patient had, about simple things like what was done in the emergency room, the patient wouldn't know because things were going so fast, fast, fast. I would go into the room and say 'Mr. Smith, I know you came in because you're having chest pain' so then he'll think the doctor knows about me and knows my name and why I'm here…This would give the patient confidence. This took me an extra 10-15 minutes, much longer at first, but it would put the patient at ease and feel like everything was under control.[310]

Dr. IB's way of interacting with his patients suggests a therapeutic relationship with an emphasis on empathy and understanding. His consideration of the affective, as well as the biological duress that patients experienced inflected his caregiving with a less hegemonic form of masculinity that was not emotionally devoid and ultra rational. Dr. IB's way of seeing the patient was outside of the structured way of seeing illness that Foucault described in *Birth of the Clinic*. Although his performance rejected a biologically

[309] Dr. IB, interview with author, Illinois, August 3, 2015.
[310] Dr. IB, interview with author, Illinois, August 3, 2015.

reductionist approach and recuperated the sick individual in the interaction, it also suggests that his social location did not allow him to access the dominant norms, which emphasized scientific rationality, disinterest, and the unwavering projection of authority. Dr. IB accessed modes of care and behavior considered more feminine in character thereby conceding some power and authoritative privilege in the interaction.

The doctor patient interaction is a performance of a particular social order. The doctor, legitimated as an expert through training and credentialing, is expected to display this in the clinical interaction and the patient is the audience for this production. Historians Michael Wintroub and Peter Heering understand performance as choreography of truth and interrogate the power dynamics within performance. Wintroub shows how performances have historically operated as demonstrations of political power. It is a ritualistic display that concretizes the distance and the social location of the performer and the audience.[311] Heering argues when the audience is recruited into the performance ritual, this could have the effect of subverting the performer's authority.[312] I use these insights to analyze the dynamic between Dr. HM and a patient. Dr. HM, a physician from India, worked at a community hospital in the Midwest and described his technique for taking patient histories. He explained this was different than standard protocol because he began the clinical visit by addressing the proximate cause for the visit and then proceeded with the patient history. Dr. HM commented on his decision to reverse the standard protocol when he entered clinical practice in 1983:

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[311] Michael Wintroub, "Taking a Bow in the Theatre of Things," *Isis,* 101 4(2010): 779-793.
[312] Peter Heering, "The Enlightened Microscope: Re-enactment and Analysis of Projections with Eighteenth-Century Solar Microscopes," *British Journal for the History of Science,* 41(2008): 345-367.

> I started by looking at the records and the labs for five minutes and then I'm ready for the patient. So when I started like that, [and dealt with the immediate problem] it put the patient at ease…The patient gets irritated when they don't know what's happening to them and I ask them 'well what about your mom? Is she alive or deceased? Did your father smoke?' The patient says he doesn't care. He wants to know what is in his labs and tests…After I give them the initial [information], I told them that since I don't know you, I would like to ask you a few questions and you can ask me some. That was another trick I learned…I would make a team with the patient and myself. You stop me if you have any questions and I'll stop you if I have any questions…It was about communication.[313]

Dr. HM recruited the patient in the clinical interaction by creating a "team." This discursive move diminished the asymmetrical power dynamic embedded in the scenario by conceding that the patient possessed information that Dr. HM needed, but did not have access to. In this way, Dr. HM enrolled the patient in the performance by actively involving him and elevating the patient's status as a collaborator. In this interaction, there is an inversion of the expert and the non-expert, which created intimacy and unmasked the ritualistic and hierarchical aspects of the doctor patient relationship. Dr. HM's interaction was in line with the shift to better communication and dialogue ethicist Jay Katz promoted in the 1970s as a way to curtail the hegemony of US physicians.

While the doctor-patient relationship is arguably the most central aspect of the clinical space, interactions with nurses and other staff were instrumental in situating a foreign physician in the hospital. When Dr. AA first arrived at Cook County unsure of himself and the space he recently entered, in, he recalled a formative experience that marked him as different:

> "You realized if there was a white resident or intern, the staff was much different to them than to us. The clerical staff or the transpiration people – when they [white physician] asked for something they would do it quickly and when we

[313] Dr. HM, interview with author, Illinois July 27, 2015.

> asked for something, they did not. And I think that was a racial side of things. The black [support staff] thought the whites were more than us. They were used to this. One resident warned me of this. He said don't worry about. You might have to ask for something twice or thrice, but insist on it and they will do it."[314]

Rosenberg's observations about the hospital as a microcosm of the social world outside its walls incisively described Dr. AA's struggle to situate himself in the American racial hierarchy. He notes the preferential treatment given by black staff to white doctors framing the interactions in terms of a historical memory of domination, which imbued the white, male physician with ultimate power and authority – "they were used to this." Into this racialized structure, "when [FMGs] asked for something," there was a disturbance to the hierarchy since these physicians defied physician norms. And in order for their requests to be fulfilled, it was common knowledge amongst foreign physicians that repetition was key, "insist on it and they will do it." In the reluctance to comply and the need to repeat, a compromise was worked out. The black staff is suspicious of a foreign physician's authority and the foreigner must insist on their position multiple times to persuade the staff they deserve recognition. Their authority is conditional.

Interactions between FMGs and female nursing personnel were sites of gender and power negotiation, often lessening the hierarchical relationships historically embedded in the respective professions. When discussing these interactions, foreign physicians interviewed foregrounded their ignorance of the position of American nursing in relation to its lesser position in the South Asian context. Sujani Reddy elaborates on this in *Nursing and Empire* arguing that nursing carried a stigma making it an undervalued and underpaid lacking respect and prestige for much of the colonial period.

[314] Dr. AA, Interview with author, Illinois, July 23, 2015.

Reformers, as part of their civilizing missions, attempted to organize and professionalize nursing in South Asia to remove these pejorative stains. Remnants of this attitude migrated with foreign physicians but were quickly challenged as foreign physicians came to depend on US nurses for medical as well as cultural guidance. Dr. AH recognized his mistaken attitude towards the nursing staff early in his clinical days. He recalled: "I walked into work and said 'Hi, Sweetie!' to a nurse and she was not happy. She turned around and said 'I am not your sweetie. Don't talk to me like that.' I was just trying to act in this way, but after that I never did it again. I never said sweetie or honey."[315] Dr. AH was attempting to perform a dominant masculine role by reciting verbal scripts he thought were available to him as a doctor. Hence, Dr. AH was surprised by the nurse's cutting reply and rejection of this diminutive salutation. Whether the nurse would have accepted this greeting from another physician is unknowable. However, the imprint of the rejection Dr. AH caused him to shy away from posturing and adjust his behavior in future interactions. This banal encounter served as reminder of his position within the medical hierarchy. Not only did nurses provide medical assistance and advice to foreign physicians, FMGs reported on nurses' social and cultural contributions to care work. Nurses deftly filled in cultural gaps in knowledge, such as explaining to a FMG that a screwdriver was also an alcoholic beverage. In these moments of cultural asymmetry, nurses subverted normative power dynamics assuming a dominant position in relation to foreign physicians.

Many FMGs reported utilizing extra time, conducting additional medical

[315] Dr. AH, interview with author, New York, February 20, 2015.

research, adopting a deferential attitude to patients, and undertaking further English language study to effectively navigate clinical interaction. While these practices certainly improved patient care, I suggest that they were undertaken as a result of structural constraints. Over time, as the medical profession consolidated its image and authority, it naturalized a particular version of a physician. This individual embodied a masculinized expertise characterized by authority, leadership, and direct action. However, historically dominated groups could not utilize the same performative repertoire. Dr. BK voiced frustration with this position: "This is what makes you feel so bad. Here is the American graduate because he knows how to talk and understands the system better, he looks ten times better than you, when you *know* as much as he does or maybe more. But that is the reality of the system. It's what you have to deal with."[316] In narrating the mundane, seemingly routine experiences of clinical practice, the brief episodes above emphasize the nuances and dynamics of power that marked the experience of FMGs as different from their US counterparts. While it must certainly be true that US physicians also negotiated and performed their expertise and authority in individuated ways, their inclusion into the profession was not discordant with expectations about the profession. This was not the case for the FMG in the early days of the physician migration. Their expert status granted them the label of physician, but their foreignness prevented full entry into the medical profession. As time went on, FMG presence in the healthcare industry became an expected mainstay of the profession. However, traces of foreignness remained.

Conclusion

[316] Dr. BK, interview with author, Burr Ridge, Illinois, March 9, 2015, 57.

In 1988, *Medical Economics* published "How Much of Malpractice Can Be Blamed on Bad Doctors?" The author listed fifteen warning signs to consider when choosing a physician. At the top of the list was a foreign physician. Over twenty years after their initial arrival, FMGs were characterized in disparaging terms despite the consistent demand for their medical services. FMGs continued to be characterized in disparaging terms despite the steady demand for their medical services for over twenty years. The data show that FMGs had equal or fewer malpractice suits than their US colleagues, suggesting the negative characterizations were less about actual services provided and more a response to the challenge FMGs posed to normative physician identity. During a time when the authority and prestige of the medical profession was in flux, with a general downward trajectory, foreign physicians complicated the professional physician image. They were doctors -- legitimated, credentialed MDs -- yet disrupted the order of things. As Fanon observed in reference to himself, "All around [their] bodies reigns an atmosphere of certain uncertainty."[317] Fanon's insights resonate with the experience of FMGs in the United States; their bodies rendered them as *foreign* doctors, physicians located outside of normative physician constructs. Organized medicine evaluated FMG performance in terms that discursively reproduced colonial hierarchies and classifications. Foreign physicians were less rational, less assertive, less independent, overall rendering them less capable than their US counterparts. Nevertheless, demands of the labor market ignored these critiques and FMGs provided services in underresourced communities across the United States.

[317] Fanon, *Black Skin, White Masks,* 90.

Unable to marshal the full cultural authority and capital associated with their professional title, foreign physicians infused their doctoring with elements of care that were not required of their US trained male, white, upper class colleagues. FMGs reported attending to these aspects of the clinical encounter as especially necessary during the initial period of physician migration when US publics were largely unfamiliar with them. The clinical interaction is a productive site for this analysis because it staged a confrontation between bodies that were often segregated spatially and socially. Doctoring forced an interaction of the most vulnerable kind, requiring physical, emotional, and psychological intimacy. In this interpersonal space riddled with anxiety and uncertainty, issues of identity and difference are unmistakably exposed.

The power of dominant, normative constructs of physician's corporeal compositions and the expertise and authority embedded in these bodies should not be underestimated. During an interview with Dr. AA, a successful hematologist-oncologist originally from Pakistan, the degree of embeddedness of hegemonic expectations is made apparent.[318] He narrated the following story about his brother, also a Pakistani FMG: "My own brother had to get a physical exam done and asked me for [doctor] suggestions. He said he wanted to see someone who was an American doctor, not an Indian or a Pakistani." Dr. AA continued to explain, "In our subconscious, those things are there."[319] Fanon's assessment regarding the historical legacies of colonialism and their enduring effects in mental structures is useful for understanding this ironic contradiction. Because

[318] Mark Granovetter, "Economic Action and Social Structure: The Problem of Embeddedness," *American Journal of Sociology* 91(1985): 481-510.
[319] Dr. AA, interview with author, Illinois, July 23, 2015.

FMGs were exterior and always foreign, they were tied "to an image, snaring him, imprisoning him as the eternal victim of his own essence, of a visible appearance for which he is not responsible."[320] Thus, even as Dr. AA's brother envisioned himself as a talented practitioner, there were elements of his sense of self, mediated through an external gaze, which marked FMGs as inadequate practitioners. It is in these subconscious "imprisoning" structures that the desire to see an American physician, who was considered to be a better physician simply by virtue of his status as an American, originated. His statement is indicative of his subject position within the medical hierarchy.

Despite the challenges FMGs faced and the stories they shared, there was a reluctance to acknowledge explicitly discriminatory practices. Comical anecdotes or stories narrating difficulty were quickly offset with statements such as "but medicine is colorblind" and "we came based on our own choice and anything is possible in America."[321] In the coupling of these stories and statements, there is what theorist Homi Bhabha wrote, "the disturbing distance in-between that constitutes the figure of colonial otherness."[322] Bhabha's remarks were written as a commentary on Fanon's autobiographical observations where he described the colonizers reactions to his position

[320] Fanon, *Black Skin, White Masks,* 18.
[321] For more on colorblindness and postraciality, see: Eduardo Bonilla-Silva, *Racism Without Racists: Color-Blind Racism and the Persistence of Racial Inequality in the United States* (Roman and Littlefield Publishers, 2006); Amanda Lewis, " 'What Group?' Studying Whites and Whiteness in the era of 'Colorblindness'," *Sociological Theory,* 22(2004): 623-646; Charles Gallagher, "Color-Blind Privilege: The Social and Political Functions of Erasing the Color Line in Post Race America," *Race, Gender and Class* 10(2003); Osagie Obasogie, *Blinded by Sight: Seeing Race Through the Eyes of the Blind* (Stanford: Stanford University Press, 2013).
[322] Homi Bhabha, "Remembering Fanon: Self, Psyche, and the Colonial Condition," in *Colonial Discourse and Post-Colonial Theory: A Reader* eds. Patrick Williams and Laura Chrisman (New York: Routledge, 2015), 117

as a physician: "You're a doctor, a writer, a student, you're different, you're one of us." It is in this elicitation of being "one of us" while necessarily being "different" that Fanon's perpetual liminality was situated; "Not yet white, no longer completely black…"[323] Fanon, in a similar position to foreign physicians in the United States, experienced a sense of fissure and splitting in this acceptance through negation. Foreign Medical Graduates were forever foreign as their classificatory label suggested. Their permanent orientation was towards the outside of the profession as well as outside of the US civil sphere due to their foreignness. In oral histories, FMGs express a sense that their existence in the United States was bestowed as a gift, a token that has created a relation of indebtedness, which has the effect of muting narratives of discrimination and difficulty. The citizenship-for-service gift is given in such a way that it invokes a desire to erase negativity because the foreign physician is allowed to accumulate social benefits due to their professional affiliation. These benefits were ostensibly enough for an immigrant – anything beyond is not a part of the immigrant contract. In the next chapter, I transition to the political investigating the "Fight for Equality" foreign physicians waged against organized medicine and the government. During the course of this fight, South Asian foreign physicians began to pull away from the foreign conglomerate forging a collective political identity in the public realm while Navin Shah simultaneously forged a political identity in the private realm.

[323] Bhabha, *"Remembering Fanon,"* 117.

CHAPTER 4: POLITICAL BRANDING

After four years working in the United States, Navin Shah, the physician introduced at the start, proudly returned to India to repay his educational loan in 1977. Shah's repayment exceeded the loan amount three times over, a total of 10000 rupees, because he "was a rich guy now" and wanted to show his appreciation. Soon after his short trip to India, Shah began to worry about his children's disconnect from India and their future lives as hyphenated Americans. This anxiety, combined with the realization that the number of Indian physicians in the area was growing considerably, motivated Shah "to get together and do something." He invited the Indian physician colleagues he knew to a local hotel and paid "$500 for dinner arrangements for his guests." Shah asked them to consider the following question: "How do we sustain ourselves in this society?" The collective's solution was to create an association for Indian doctors called the American Association of Physicians of Indian Origin (AAPI). The organization served two main purposes: to promote Indian cultural activities and to address conditions facing FMGs who were treated like "second rate doctors...working in some small hospital, some ghetto place, or asylum."[324]

In the 1980s, Shah and his colleagues were animated by this question as the political climate turned against foreign physicians. They were accused of contributing to a possible physician surplus crisis. This chapter begins with an investigation of possible physician oversupply during this period with attention to the uncertainty rampant in the healthcare system. Next, it documents the formation and political actions of the Alliance

[324] Dr. Navin Shah, interview with author, Potomac, MD, June 14, 2014.

of Foreign Medical Graduates (later to be called the International Association of American Physicians) largely through the organizational efforts of one important node in the network, Navin Shah. By creating a coalition with other contingents of FMGs -- "Pakistani doctors, the Islamic doctors, the Filipino doctors," -- Shah was instrumental in a campaign to level the structural barriers between Foreign Medical Graduates and US medical graduates. In his testimony before Congress, Shah explained the concerns: "Since 1980, all of a sudden, for various known and unknown factors, State and national medical bodies branded directly or indirectly the FMG's as second rate doctors. A number of FMG's have suffered a lot of injustice, tremendous economical loss and mental anguish the areas of jobs, promotions, hospital privileges, licensing, and reciprocity."[325] With the removal of these institutional barriers, FMGs hoped interpersonal discrimination would subside. They would be considered equal doctors. In 1992, their grievances were acknowledged with the passage of the Health Professions Reauthorization Act and their "brand" began to change. While, the story of FMGs' struggles for fair treatment in the United States exceeds the narrative of Shah, centering his experience allows for critical insight into the labor and capital necessary for political mobilization in the United States.

This historical narrative is built on Navin Shah's archive, comprised of both documents and oral history and is analyzed in the final section. In his personal archive, the personal, the political, and the institutional are inextricably linked allowing for an

[325] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 408.

analysis between documentary practices and self-making. In addition to his role in the historical narrative, Shah became the archivist of the "fight for equality," amassing a sizeable collection of documents. Placing the archive alongside the autobiographical narrative allows for an analysis of the entanglements between documentary archiving and personal memory, privileging neither form over the other. It is a way to hold the verbal ordering and the textual ordering of events simultaneously. Each source effaces a part of the story. However, juxtaposing them allows for materials to overlap and interfere revealing gaps, deliberate omissions, and repetitions, integral components in the production of political subjectivity.

Shortage to Surplus?

In 1976, the physician shortage crisis discursively morphed into one of possible oversupply. During the 1960s, legislators' implemented medical education and infrastructural reforms predicted to mature in the late 1970s and early 1980s producing enough US doctors to serve the population's needs. This meant the relatively unrestricted flow of transnational physicians was no longer necessary and policymakers were charged with stalling the migration. Using emendations to the Hart-Celler Act and the Health Professions Educational Assistance Act of 1976, Congress limited FMG access and entry disrupting patterns established in the previous decade. They implemented entry requirements for foreign physicians including a Visa Qualifying Exam,[326] acceptance to a residency program before arrival, the ability to adapt to the educational and cultural

[326] This exam was intended to be the equivalent of the National Board Exam Part I and II. The National Board exams are taken by US medical students while in medical school.

environment, and a guarantee the FMG would not remain in the United States after training was complete.[327] They would be sent back to provide care in their home countries. The legislation was effective; "in terms of total positions, only 1,552 FMGs were in graduate medical education positions in 1981-1982, as compared to over 8,000 in 1973-1974."[328]

However, there was one glaring problem with this new restrictive immigration arrangement – FMGs provided essential services to shortage area communities at rates much higher than their US counterparts. The changes would exacerbate health inequities for rural and inner city residents who relied heavily on foreign physicians' services. While the expansion efforts for the US medical graduate workforce continued to gestate, the temporary solution was a waiver program for hospitals where the reduction in FMGs would cause a "substantial disruption" due to immigration changes.[329] There were two issues with the "substantial disruption" waiver as explained in the *New England Journal of Medicine:* the first was defining the parameters of substantial disruption and the second was jurisdictional accountability.[330] In 1977, Congressional hearings on Foreign Medical Graduates revealed the extent of fragmentation and confusion. Chairman of the hearing, Joshua Eilberg, sequentially asked representatives from the Department of State,

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[327] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 312.
[328] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 408, Public Health Service Act Medical Amendments of 1985, Report submitted by Orin Hatch, 14.
[329] Bernard Weinstein, "The foreign medical graduate issue and US hospitals In regard to Public Law 94-484," *JAMA*, 241(1979): 917-919.
[330] Weinstein, "The foreign medical graduate issue and US hospitals In regard to Public Law 94-484," 917-919.

the Department of Labor, the Secretary of Health, Education, and Welfare (HEW), and representatives from the Educational Council on Foreign Medical Graduates who was responsible for oversight. In an exchange with Christian Chapman from the Department of State, Congressman Eilberg voiced his dissatisfaction with the state of affairs: "this suggests to me nobody is minding the store…Mr. Chapman, would you agree no leadership is being shown in administering this very important law. This is apparent to this member. Whether it is State or HEW, or someone else, the implementation of the law seems to be floundering. I am very concerned."[331] Mr. Chapman defensively responded:

> The decision to proceed with the waiver has been a sort of collegiate decision to go ahead… Now if you push me to say it 'Who is finally responsible? Who can we hang?' I think it would be the Department of State. I am very sorry if we have conveyed that impression [of floundering]…I think there is general consensus among all of us on the facts of the situation…The law is, as I said, as I read it, a little fuzzy as to the areas of responsibility."[332]

James Dickson, the Secretary of HEW disagreed arguing, "After the initial policy and action determinations by the Secretary of HEW and issuances by the Department of State, the basic responsibility for administration in the final end lies with the Justice Department as it surveys and monitors J visas and the like."[333] The hearings exposed the haphazard nature of FMG immigration, confirming no one agency was in charge and all contributed to the chaos.

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[331] U.S. Congress, House, Committee on the Judiciary, *Hearing before the Subcommittee on Immigration, Citizenship, and International Law: Oversight of Immigration of Foreign Medical Graduates,* 95th Cong., 1st sess., 1977, 48.
[332] U.S. Congress, House, Committee on the Judiciary, *Hearing before the Subcommittee on Immigration, Citizenship, and International Law: Oversight of Immigration of Foreign Medical Graduates,* 95th Cong., 1st sess., 1977, 48-49.
[333] U.S. Congress, House, Committee on the Judiciary, *Hearing before the Subcommittee on Immigration, Citizenship, and International Law: Oversight of Immigration of Foreign Medical Graduates,* 95th Cong., 1st sess., 1977, 52.

In these hearings, the rising cost of medical care once again resurfaced in relation to foreign physicians. Congressman Harold Sawyer of Michigan asked during the hearing:

> I presume the thrust of the law, tightening it up in anticipation of our producing an adequate number of doctors domestically is basically then one of underlying economic protection of the medical profession…Perhaps as serious a problem confronting us as the number of doctors is the cost of doctors and the cost of the delivery of medical services in general. And we make tariffs, import duties, but here we are embargoing imported skills in an area where we face nothing, but a tremendous escalation in cost. And I wonder if it is in the national interest to tighten that up as opposed to just being in the interests of the medical profession.[334]

Sawyer astutely linked immigration, cost, and occupational closure, concerns that occupied policymakers throughout the 1980s. Medicare and Medicaid reimbursements reached new highs due to an increase in the number of enrollees and changes to medical care practice and billing. Hospitals were transformed into integrated corporate structures, housing diagnostic technologies and many specialties in one physical location. This consolidation provided ease of access and greater connectivity in medical care resulting in an increase in referrals and medical procedures, which Medicare was expected to reimburse. In addition to increased costs due to increased medical services, Medicare was the primary funding channel for Graduate Medical Education (GME). GME included stipends for medical residents as well as financial support for hospitals that accepted these training doctors. GME was a costly endeavor and a considerable burden for under resourced hospitals. To ensure that financial strain would not disrupt doctor training,

[334] U.S. Congress, House, Committee on the Judiciary, *Hearing before the Subcommittee on Immigration, Citizenship, and International Law: Oversight of Immigration of Foreign Medical Graduates,* 95th Cong., 1st sess., 1977, 51.

Congress legislated GME under Medicare as a mechanism to stabilize the training system by bypassing local economic issues. When the proposition was introduced in the mid 1960s, Congress did not anticipate bearing such a heavy economic burden in relation to medical education and training. Nevertheless, the system remained. By the early 1980s, amidst the deep recession and budget cuts of the Reagan administration, legislators turned their attention to GME as a possible program to cut in the face of rising deficits.

In 1982, the Advisory Council on Social Security studied the economic state of the Medicare fund feared to become insolvent by 1990. The commission determined if Medicare payments for Graduate Medical Education were eliminated by 1987, there was the possibility of saving nearly forty billion dollars by 1995.[335] If these cuts were enacted, FMGs would be first to feel the effects since they worked in hospitals that could not have residency programs without federal financial support. In an American Association of Medical Colleges position paper entitled "Medicare's Graduate Medical Education Policy," the authors identify a major flaw in Medicare entitlements related to the GME issue. GME infrastructure is legislated through Congressional budgetary committees with only minimal knowledge of the "intricacies of the physician workforce, academic medicine, and the role GME plays in shaping both." This disconnect has resulted in an uncoordinated approach to training the physician workforce that was more responsive to hospital budgetary concerns rather than health care needs of the population.[336]

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[335] Shawn McMahon, *Fight For Equality: International Medical Graduates in the United States* (Maryland: Potomac Publishing, 2005), 44.
[336] "Medicare's Graduate Medical Education Policy: It's Inception and Congress's Clear and Persistent Commitment," Association of American Medical Colleges, November 2015, 6-7.

Among foreign physicians, there existed a rising concern that their already tenuous position in the healthcare system would be further compromised during this time of fiscal conservatism. FMG numbers already decreased because of the potential physician surplus, and now, their residency funding could also disappear. This fear was well founded as Congressional conversations explicitly turned towards "limit[ing] the number of positions that can be filled by graduates of foreign medical education"[337] or "eliminating them from training all together."[338] Senators Robert Dole and David Durenburger proposed legislation denying FMGs any federal funding. A week after this bill was submitted, Senators Orin Hatch and Dan Quayle, submitted a proposal suggesting at least seventy-five percent of residency positions in GME funded programs be filled by graduates of schools approved by the Liaison Committee on Medical Education. All schools on the approved list were located in the United States or Canada. Much to the dismay of foreign physicians, attempts at limiting their presence were also supported by organized medicine. In a policy report submitted to the Department of Health and Human Services, the preparers reported: "a rare consensus has emerged among the key professional organizations – the American Hospital Association, the American Medical Association, and the Association of American Medical Colleges – that the targets of the cutbacks ought to be FMGs."[339]

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[337] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 408, Public Health Service Act Medical Amendments of 1985, Report submitted by Orin Hatch, 2.
[338] McMahon, *Fight for Equality,* 46.
[339] "Analysis of Costs and Services Associated with Graduate Medical Education Programs in FMG Dependent Hospitals," February 1987, 5, in personal archive of Navin Shah, Potomac, MD.

Although the proposed bills were never voted into law, the legislation signaled an increasingly antagonistic orientation toward FMGs. As the era of doctor shortage was projected to end by the mid 1980s, fear of surplus replaced concerns of shortage. This new crisis of physician oversupply could have negative economic consequences for the country. In the new fiscal environment, FMGs were understood to be superfluous, underperforming physicians who extracted from the healthcare system. However, there was always one caveat to these pronouncements, foreign medical labor was essential in rural and urban shortage area communities. In the policy report mentioned above, it was reported: "nearly half of the patient population in the average FMG dependent hospital is elderly and/or poor. One out of every five discharges is a Medicaid patient; one out of every four is a Medicaid beneficiary."[340] Even with Hatch and Quayle's proposed legislation, which attempted to have 75% of residency spots filled by US medical graduates, they included a "substantial disruption waiver" for hospitals that relied heavily on FMGs, recognizing the disproportionate amount of care FMGs provided underserved communities.[341] Additionally, their presence in these communities was arguably a cost-saving strategy. In a report submitted by Policy Analysis Inc., a health-consulting firm, to the Department of Health and Human Services, the researchers showed, "replacement of [FMGs], even where technically feasible, is not likely to be cost effective. The estimated

[340] "Analysis of Costs and Services Associated with Graduate Medical Education Programs in FMG Dependent Hospitals," February 1987, 135, in personal archive of Navin Shah, Potomac, MD.
[341] "Analysis of the Cost of Replacement of Services Provided by Foreign Medical Graduates to Medicare Beneficiaries," Policy Analysis, Inc., January 15, 1988, 5-6, in personal archive of Navin Shah, Potomac, MD.

net annual cost of replacement, stated on a per resident basis, generally ranged between $10,000 and $75,000, and often was substantially higher."[342]

During the mid 1980s, despite the findings of this report, the negativity FMGs experienced could not be ignored. Small, local enclaves of foreign doctors with shared ethnic commitments shifted their priorities from the cultural to the legislative realm mobilizing in response to professional threats. This transition required significant coordination, maneuvering, and crafting to organize around shared strategies and goals. Navin Shah, a central actor in politicizing foreign physicians explained his heavy investment in the legislative battles to come: "Gandhi fought for everything against the mighty British Empire. I didn't know whether Gandhi's experience was like mine or mine like Gandhi's, you just talk about it. This is not even my country and Gandhi was in his own country, but right is right. I had to do it."[343] "I was representing 180,000 total foreign doctors."[344] The imprints of colonial domination, the background scenery during his walks home from the soap factory, informed Shah's relationship to the United States. Using Gandhi's anti-colonial struggles as his analogy, something "he just talks about," Shah is located in multiples; he simultaneously imagines himself as a Gandhi-like figure fighting against occupation, yet his struggle is ultimately for inclusion in a country that "is not even [his country]." His comments gesture towards "the disconnections between

[342] Analysis of the Cost of Replacement of Services Provided by Foreign Medical Graduates to Medicare Beneficiaries," Policy Analysis, Inc., January 15, 1988, 9, in personal archive of Navin Shah, Potomac, MD.
[343] Dr. Navin Shah, interview with author, Potomac, MD, February, 28, 2015.
[344] In 1990, the American Community Service data reported there were 136,094 foreign born physicians practicing in the US. I'm not sure if Shah included US FMG's in his 180,000 estimate.

place and identity, the local and the global, and the importance of the imaginary in any evocation of 'experience.'"[345] These layered temporalities, the after-lives of empire, reveal his understandings of self to be in perpetual motion between two places and contexts.[346]

FMGs Politically Organize

The initial gatherings of the American Association of Physicians of Indian Origin (AAPI) were small. The programming largely designed to confront diaspora related anxieties was oriented towards language classes and dance performances. As meetings became more regular, trust between members developed and conversation shifted away from superficialities. Members began discussing the difficulties and discriminatory treatment they faced in their professional lives. Shah recognized the scale of these issues was significant and warranted concerted attention and effort. He recalled, "The thought came to me that we have to address these issues. Even though you're trained here, you passed the exams, you passed their boards, you got a license, everything is done per the requirements, and yet, some hospitals wouldn't give promotion, some wouldn't give certain privileges and moving from state to state was [very difficult]."[347] Drawing on lessons learned from the "struggles of the leaders" in India, Shah recognized the importance of growing the organization if there was any possibility to address these concerns. He turned to the Indian ethnic newspaper published by the embassy of India

[345] Sandhya Shukla, "Location for South Asian Diaspora," *Annual Review of Anthropology* 30(2001); 555.
[346] Achille Mbembe, *On the Postcolony* (California: University of California Press), *14*.
[347] Dr. Navin Shah, interview with author, Potomac, MD, June 14, 2104.

and "put an advertisement about a [national organization]. From there I got a lot of responses. Many places like New York, California, or Ohio, had small groups and association," but Shah was committed to a national organization. In the late 1970s, there was only one national FMG organization in existence, the American College of International Physicians (ACIP). Although it aimed to be inclusive of all foreign physicians, there was a strong Filipino contingent that dissuaded other ethnic physician communities from joining, according to Shah.[348]

In the early 1980s, national ethnic physician organizations slowly formed across the country – American College of International Physicians, American Association of Physicians of Indian Origin, Association of Pakistani Physicians of North America, and the Association of Philippine Physicians in America, the Islamic Medical Association. In 1985, Shah prearranged with the leadership of each of each organizations to convene their annual conferences in the DC Hyatt Regency during the same weekend. He "called all the groups" of which the "Indians, Pakistanis, and the Filipinos" were the largest and discussed the need for an alliance between them. Leaders of the various contingents agreed and together, they formed the Alliance of Foreign Medical Graduates.[349] The Alliance became a politicized entity committed to ending discrimination towards foreign physicians on two fronts: organized medicine and Congress.

American Medical Association

[348] McMahon, *Fight for Equality*, 52.
[349] Dr. Navin Shah, interview with author, Potomac, MD, June 14, 2014.

The Alliance agreed it was necessary to secure the support and allegiance of the AMA for the foreign physician cause since the AMA wielded considerable political capital in Washington. If Alliance leaders could convince the AMA to support their fight for equality, success was inevitable. Furthermore, FMGs also targeted the AMA because they were members of the organization and felt it was the AMA's responsibility to support their constituents. To this end, foreign physicians targeted the creation of an AMA section specifically dedicated to their unique grievances as a necessary first step in their political fight. In 1988, Dr. Virendra Bisla, head of an Illinois chapter of foreign physicians explained to a Congressional committee:

> It is the responsibility of organized medicine to be sensitive to these doctors and also because a substantial number of these doctors are a part of organized medicine it is important for the AMA to be involved in the welfare of these doctors and help them to eliminate the discrimination, and thereby become more relevant in the day-to-day activities of these doctors who were trained abroad.[350]

Shah corroborated this opinion stating in an interview, "[we thought] it was better to be in the game and complain from the inside."[351] After considerable resistance, the AMA conceded to establish an ad hoc committee charged with examining whether foreign physicians' concerns required special consideration or were no different than general members' concerns.

During an open AMA session in Chicago on January 24, 1986, FMG representatives articulated their grievances accusing the AMA of treating them as

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[350] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 410.
[351] Dr. Navin Shah, interview with author, Potomac, MD, February, 28, 2015.

"second-class citizens in this country."[352] Dr. Antonio Donesa, a Filipino organizer and head of the American College of International Physicians, accused organized medicine of straddling the "fine line between legitimate investigations of the quality of foreign school and their graduates and persecution. This unsupportive treatment made foreign physicians feel "abandoned and left to die on the vine by medical organizations such as the American Medical Association."[353] Donesa's frustration over the perpetual erection of barriers for foreign physicians was seconded in the testimony of Dr. Kishore Thampy, chairman of the International Medical Council of Illinois. He admonished the AMA for their passivity in the face of injustice stating:

> It is not enough for the AMA, a fifth of whose membership is composed of FMGs, to continue its passive role on the segregation of and discrimination against FMGs in the U.S. medical system. The medical apartheid must be tackled immediately and forcefully. The creation of an unending stream of ad hoc advisory committees whose pious and often lukewarm recommendations are never implemented where they matter cannot be tolerated any longer.[354]

FMG leaders were frustrated with committees, organizations, and recommendations that failed to produce meaningful positive improvements in their professional lives. The rhetorical invocation of "apartheid", "discrimination", "second-class citizens" suggested perceptions of the struggle were influenced by postcolonial sensibilities and histories. Their fight was located along this continuum. FMG leadership expressed skepticism and dismay with the gradualist approaches presented to them over the years. There was no

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[352] Christine Hinz, "FMGs Complain About 'Second Class' Status," American Medical News, February 7, 1986, 14.
[353] Christine Hinz, "FMGs Complain About 'Second Class' Status," American Medical News, February 7, 1986, 14
[354] Christine Hinz, "FMGs Complain About 'Second Class' Status," American Medical News, February 7, 1986, 14.

longer time for ad hoc committees populated with unsympathetic AMA members. The political organizing fervor was high and FMG leaders demanded a special section focused on eliminating discriminatory practices they faced.

During the July 4th weekend in 1986, the Alliance convened their second national conference in DC passing three resolutions to orient their future actions. As reported by *India-West,* an Indian diasporic community newspaper, these included:

> One national board exam for US and foreign-trained medical graduates; reciprocity in state licensing policies to prevent discrimination against FMGs who move from one state to another; and rejection by the Department of Health and Human Services of any proposals that limit Medicare and Medicaid funding for hospitals to employ FMGs as interns and residents."[355]

Their objectives were to establish the same exams, the same licensing procedures, and the same treatments for foreign physicians and their US contemporaries. Shah repeatedly stated, "We didn't want anything special, we just wanted equality." To achieve their goals, the Alliance would have to continue pressuring the AMA and begin to appeal directly to Congress. As the co-chairman and spokesman for the Alliance, Shah took a leading position collecting discrimination narratives to present to the AMA to strengthen the appeal with the human element. However, this project was proved more difficult than expected. FMGs who faced discrimination were reluctant to document their complaints in writing. But without a considerable number of written complaints as evidence, Shah felt hesitant approaching the AMA again.[356] He recalled, "I would say that three times the

[355] Vincent Digirolamo, "FMG Discrimination Focus of AAPI Convention," *India West*, July 25, 1986, 13.
[356] Dr. Navin Shah, interview with author, Potomac, MD, February, 28, 2015.

complaints were not given. I only received 33 or 35 percent of the complaints [I heard] in writing. People were not ready to write it down."[357]

FMGs' unwillingness to document grievances can be understood as a response to the immigrant contract, the feeling that legal citizenship and entry into the United States should be accepted without complaints. In documenting their grievances, foreign physicians feared transgressing the terms of this contractual invitation. As historian Margaret Somers explains, this contractual citizenship "distorts the meaning of citizenship from that of shared fate among individuals to that of conditioned privilege." The privilege to work in the United States and earn at rates exceeding possibilities in home country should be accepted gratefully. Furthermore, producing a complaint in the form of a written statement was an act that concretized their distance or exteriority with a textual permanence. Producing documentation elevated the grievance from a vague affective experience of injustice to an actionable and circulating piece of evidence with a juridico-political valence. The document became a form of testimony or record and many FMGs resisted this commitment. Over time, Shah was able to amass a significant number of complaints and scheduled a meeting with James Sammons, the executive president of the AMA to show him the volume and nature of the complaints he collected. "After three months I got a meeting in Washington [with Sammons] and I asked for half an hour. [Sammons] came twenty-five minutes late and said I have to catch a flight and there are no special privileges for you and you're like other members and this is America and there is no discrimination here. And he said if you feel like there is discrimination, go to the

[357] Dr. Navin Shah, interview with author, Potomac, MD, February, 28, 2015.

courts." AMA continued resistance to foreign physicians was obvious. The strategy of working "from the inside" was not yielding the desired effects.

In June 1987, the AMA House of Delegates, the policy-making apparatus of the organization, held an official vote on the question of a FMG section. In the lead up to the vote, Alliance members felt positively and were armed with well-rehearsed arguments. However, despite their best efforts to garner support, the hearings preceding the vote left Alliance members dejected. Opposition to the FMG section from foreign physicians themselves was the most upsetting. Some accused FMG activists who were in favor of a special section of trying to "sneak in through a back door"[358] or "segregate its members."[359] Dr. Bisawamay Ray, an opponent of the section was quoted in *India West*: "FMGs should be in the mainstream of organized medicine. It's better to be in the mainstream." Ray went on to explain a special section "would appear as though they were asking for special privileges as if we were something special, or separate, or narrow-minded…The door is open and the system is fair."[360] Dr. Ulrich Danckers, a non-Asian FMG practicing for 25 years and an Illinois delegate to the AMA, stated during the deliberations: "The Chicago and Illinois medical societies have always opposed the idea of a section [for FMGs] as counterproductive to integration…We cannot afford to have

[358] Vincent Digirolamo, "Exodus Threatened as AMA Nixes Section for Foreign Trained Doctors," *India West,* San Leandro, California, July 19, 1987, 21.
[359] Arsenio Oloroso Jr., "Delegates Reject Forming Section for FMGs in House," *American Medical News,* July 3/10, 1987, 40.
[360] Vincent Digirolamo, "Exodus Threatened as AMA Nixes Section for Foreign Trained Doctors," *India West,* San Leandro, California, July 19, 1987, 21.

our house divided."[361] After hours of deliberation, the proposal was rejected by a vote of 215 to 145.[362]

These two oppositional stances within the FMG contingent are reminiscent of positions often held by minority groups seeking redress for harms in the post civil rights era. On the one hand, there are those who believe that positive change is a process with a gradual pace and that delay is an intrinsic aspect of the liberal project. This way, those in dominant positions will feel less threatened by the incremental demands and more amenable to accommodating small requests for fairness and equality. In this iteration, the minority group subsumes difference and denies their historical particularities to assimilate into the universal or the unmarked, with a strong reliance on the "system" to self-correct the injustices built into it over time. On the other hand, the position that the most vocal FMG leaders adopted, one where the language of apartheid and second class citizenship was used foregrounded difference. They argued that their transnational migration was unique and their position within the healthcare system was different from the "mainstream." By virtue of their historical and social realities, their difference should be actively recognized instead of ignored. This was not a move to isolate the FMG contingent from the rest of the physician workforce. Instead, it was a political demand made with the starting premise of difference. Ultimately, although the starting premise of the two factions was not the same, the end goal was – inclusion within the liberal, democratic project. Foreign physicians were not seeking any radical rupture.

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[361] Arsenio Oloroso Jr., "Delegates Reject Forming Section for FMGs in House," *American Medical News,* July 3/10, 1987, 40.
[362] Aziz Haniffa, "AMA Takes Steps Favoring FMGs: Criticism Spurs Special Cell for Foreign Graduates," *India Abroad,* New York edition, April 21, 1989, 37.

Congress

AMA resistance to the FMG cause disheartened many in the movement. Dr. Busharat Ahmad, a delegate from Michigan, was quoted in *India West* saying, "I am mad, upset. I am very disgusted with this house. The message [the AMA] is sending is one of prejudice and bigotry."[363] Shah, speaking on behalf of the Alliance shared this sentiment adding, "We are deeply disappointed, dejected, and disillusioned. We have knocked on the doors of conscience of the AMA for a decade"[364] to no avail. Leaders of the Alliance regrouped after the AMA vote and decided to shift the bulk of their political efforts towards Congress. However, the loosely formed Alliance was in its formative stages and the political process was opaque. Serendipitously for this nascent group, Kern Smith made a medical appointment with Dr. Shah one afternoon. During the clinical interaction, the conversation shifted to politics. As it turned out, Smith was a veteran Washington lobbyist who was available for hire and the Alliance was in need of a lobbyist to advise their political efforts. It was a mutually beneficial appointment.

Shah was located in the Washington DC area and almost exclusively put in charge of lobbying efforts. This task came with the burden of vetting the lobbyist and ensuring that the funds collected from Alliance members for these endeavors were not misspent. Shah, who was a novice to the process, was hesitant and fearful of transgressing

[363] Vincent Digirolamo, "Exodus Threatened as AMA Nixes Section for Foreign Trained Doctors," *India West,* San Leandro, California, July 19, 1987, 21.
[364] Arsenio Oloroso Jr., "Delegates Reject Forming Section for FMGs in House," *American Medical News,* July 3/10, 1987, 40.

boundaries of legality. Kern Smith wrote the following to Shah on February 26, 1987 to assuage his fears:

> You have raised a question about me being a legal lobbyist. You have a right to be cautious, but let me assure you I understand clearly the provisions of the lobbying act…Remember lobbying is not like being a licensed physician. Anyone can lobby, there are no qualifications necessary…You are now perhaps deciding who will represent you on perhaps this most important project in your life. You can share in the American dream, but you must have a winner. You must have a team that has the contacts with those who make the decisions.[365]

To get the FMG contract, Smith tailored his response to draw jurisdictional boundaries between Shah's medical expertise and his own political knowledge. With the assistance of Kern's firm (which also included retired Indiana senator Vance Hartke), FMGs marginal position and inadequate knowledge of the political system could be alleviated allowing these immigrants the possibility to "share in the American Dream." Foreign physicians would continue to experience exclusion unless they enrolled the appropriate allies. Shah received supportive reference letters from Jim Wright, the Speaker of the House, and Robert Mrazek, Whip at Large, vouching for the sincerity and capabilities of Vance Hartke and Kern Smith. Speaker Jim Wright wrote: "I have come to rely on [Kern] for his honest and diligent representations of his clients and their goals. And I know that because of his long contact with Congress. Kern has friends on the other side of the aisle who equally respect him."[366] Mrazek echoed these sentiments writing, "I have known Vance Hartke for almost twenty years, both as a United States Senator and as an attorney in private practice. During that time, I have never ceased to be amazed at his range of

[365] Letter from Kern Smith to Navin Shah, February 26, 1987, in personal archive of Navin Shah, Potomac, MD.
[366] Letter from Jim Wright to Navin Shah, February 24, 1987, in personal archive of Navin Shah, Potomac, MD.

contacts and his grasp of the legislative process and the ways of Washington."[367] These assurances from notable political figures bolstered Shah's confidence. On March 1, 1987, he officially hired Hartke and Smith to represent the interests of the Alliance. Under the terms of the contract, Hartke and Smith committed to the following:

> Provide more equal treatment and status of all the members of the FMG in relation to other doctors who are graduates of medical schools within the United States," "arrange for meetings with appropriate Senators, Representatives, and Staff Members, and other persons to promote the best interests of FMG," and they would "actively pursue a course of action to prevent discrimination against any FMG member.[368]

Early on in the undertaking, Hartke and Smith's lobbying efforts were slow to produce the desired results. In a monthly report to the Alliance, Hartke wrote, "To put it bluntly, the attitude [in Congress] was unfavorable. We have been using our best efforts to turn this attitude around. We are making progress. It is not an attitude that can be easily changed…FMGs are not a high priority for most senators or congressmen."[369] With the assistance of their lobbyist, FMGs had to raise awareness of their cause. They began with a soft education campaign carried out almost exclusively by Navin Shah. As the most active Alliance leader in Washington and the person with an intimate relationship with the lobbyist, he became the FMG representative on the Hill. Shah shut down his medical practice and started spending his Wednesday afternoons at the Democratic club near the Capitol building with his hired lobbyists. Congress members and their staff

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[367] Letter from Robert Mrazek to Navin Shah, February 26, 1987, in personal archive of Navin Shah, Potomac, MD.
[368] Agreement between Hartke and Kern and Alliance of FMGs, March 1, 1987, in personal archive of Navin Shah, Potomac, MD.
[369] Letter from Vance Hartke to Alliance of FMGS, September 25, 1987, in personal archive of Navin Shah, Potomac, MD..

frequented the location making it ideal for impromptu conversations about the "fight for equality." Between 1987-1990, Shah maintained this routine. Over the course of the years, he met nearly all of the legislators who would eventually support FMG legislation in the future.

Despite policy makers' initial aloofness regarding the FMG cause, there was one undeniable way to get their attention – financial donations to their campaigns. While FMGs lacked social and cultural capital due to their status as foreigners, the reality was that those in medical practice for a period of time were able to amass economic capital. This was for two important reasons: FMGs often did not have sizable medical school debt to repay after completion of residency training and they frequently established medical practices in wealthier suburban spaces once they completed their residency training in urban and rural hospitals Congressman James Bates of California, Congressman Stephen Solarz of New York, and Senator Daniel Moynihan of New York were the legislators most sympathetic to the cause. Upon the suggestions of the lobbyist, the Alliance developed a Political Action Committee donating to each campaign.[370] In an update newsletter, Shah wrote the following to Alliance leadership, "Congressman Bates had a tough election campaign and he has incurred some debt. I would request all the associations (smaller groups that made up the Alliance) to contribute 1000.00 each as soon as possible…He definitely appreciates all we have done for him in the past and he is

[370] Letter from The Keefe Company to Navin Shah, July 9, 1986, in personal archive of Navin Shah, Potomac, MD.

anxiously awaiting our positive response."[371] The financial relationship between Bates and foreign physician groups eventually raised questions. In a *The Washington Post* article, Bates' willingness to accept speaking honorariums from immigrant physician groups in the months *after* he sponsored a bill to benefit FMGs was scrutinized. The interview quoted Bates as saying, "I introduced the bill long before I was ever invited to speak...It's more trouble than it's worth…It's not like they're pumping money into me."[372] Bates conceded that some of the doctors made political donations to his campaign. However, he stopped short of ever making direct-mail appeals to foreign physicians,[373] unlike Stephen Solarz.

Congressman Stephen Solarz was the self-proclaimed representative of Indian FMGs.[374] In June 1987, invited to speak at the AAPI convention, Solarz arrived in a white sherwani (Indian attire) with a Nehru collar and a red rose pinned to his chest. Solarz recently journeyed to India with a FMG leader and reported that he had a "remarkable experience, especially [his] tour of the Indian villages."[375] In his speech, Solarz lauded the Indian physicians efforts stating, "The Asian Indian communities are one of the most brilliant people in the U.S." and the discriminatory situation FMGs faced was "intolerable and unacceptable."[376] Solarz was a shrewd politician who used his position as the

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[371] Letter from Navin Shah to Alliance directors, December 19, 1988, in personal archive of Navin Shah, Potomac, MD.
[372] Charles Babbock, "Doctors' Groups Aid Lawmaker," *The Washington Post,* November 1, 1989, A 23.
[373] Charles Babbock, "Doctors' Groups Aid Lawmaker," A 23.
[374] Shawn McMahon, *Fight for Equality*, 92.
[375] Raghbir Goyal, "Solarz Vows to Fight FMG discrimination in Congress," *India Tribune,* July 11, 1987, 17.
[376] Raghbir Goyal, "Solarz Vows to Fight FMG discrimination in Congress," 17.

chairman of the Foreign Affairs Subcommittee on Asian and Pacific Affairs to position himself as an ally to the immigrants "born in the nations he stands watch over in Congress."[377] Dr. Virendra Bisla remarked on Solarz's appeal, "How many American congressmen know what is going on in India or the subcontinent?" His fluency in issues related to the Asian community, and especially the professionally elite Asian communities, resulted in thousands of Asian immigrants, "who voting with their dollars, have adopted [Solarz] as their own." He fundraised from these communities in such a spectacular way accumulating the second largest campaign account in the House. Tapping into these communities was a serendipitous occurrence, but once "this whole Asian thing happened… we started raising money without any real effort…By and large, it is a group untouched by other politicians," explained Michael Lewan, a former aide to Solarz.[378] Solarz's appreciation for the Indian subcontinent went so far as a desire to become Ambassador to India in 1994, a nomination he was ultimately forced to withdraw.

The combination of a peculiar affinity for the subcontinent and a willingness to pursue pro-FMG legislation was also present in Senator Daniel Patrick Moynihan, ambassador to India from 1973-1975. According to Aziz Haniffa, editor of *India Abroad* newspaper and a close friend of the senator, Moynihan had "a nostalgia for India…He was the guy who really saved India from famine. He just loved India. Even now his daughter loves India. He put his name on the legislation because of his love and nostalgia

[377] Chuck Alston, "Solarz Looks Abroad to Find Election Cash at Home," *Congressional Quarterly Weekly Report,* March 11, 1989, 501.
[378] Chuck Alston, "Solarz Looks Abroad to Find Election Cash at Home," 501-502.

for India and the Indian Americans he came across."[379] An appreciation for the people and culture of the Indian subcontinent has a long history in colonial/neocolonial discourse. Whether Solarz and Moynihan accessed these scripts to understand their own experiences is impossible to know, nevertheless important to identify as a possibility.

In the fall of 1987, during the 100th session of Congress, FMG efforts began to yield cautious returns in the form of two House bills, one sponsored by Jim Bates and the other by Stephen Solarz and a companion Senate bill sponsored by Daniel Moynihan of New York. The Bates and Solarz bills were debated together in a hearing before the Subcommittee on Health and Environment in March 1988. The Bates bill, also known as the Equal Opportunity for Medical Licensure and Reciprocity Act, was drafted in extensive consultation with FMG lobbyists and Navin Shah. The purpose of the legislation was to guarantee the following: "any person that is a medical school graduate of a medical school outside the United States shall be given equal access to practice medicine within any jurisdiction in the United States. Discrimination against any graduate of a medical school outside the United States shall not be tolerated in licensure, reciprocity, reimbursement, residency, medical staff academic appointments, and professional society membership."[380] If a state violated the medical licensure and reciprocity standards that provide equal opportunities to all physicians, the state would lose their Medicare/Medicaid reimbursements. Given the jurisdictional problems over

[379] Aziz Haniffa, interview with author, September 19, 2015, minutes 65-69.
[380] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 133.

FMG management, Bates insightfully identified the Department of Health and Human Services as the bureaucratic office that should be responsible for enforcing the bill.

Representative Solarz's bill was less ambitious. Solarz submitted the Fair Physicians Reciprocity Standards Act of 1987, which stated:

> A State is perfectly free to establish whatever criteria it wants for the purpose of determining whether or not it will permit physicians licensed in other States to practice medicine in their State, but with the exception of the number of years it can require of graduate medical education, a State must not have different criteria for the graduate of the foreign medical school than it does for the graduates of U.S. medical schools."[381]

Anticipating the states' rights argument that were to come, the Solarz bill suggested that any state could establish whatever licensing criteria it deemed acceptable, as long as this criteria was used for all candidates, irrespective of the location of their medical school. The two legislators repeatedly deplored the "widespread discrimination"[382] against FMGs arguing "civil rights have not been afforded these graduates of foreign medical schools who are attempting to practice medicine in the United States."[383]

After the Congressmen introduced their respective bills, Navin Shah was summoned to testify as the FMG representative. He vividly recalled the experience:

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[381] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 226.
[382] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 228.
[383] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 141.

> I was so nervous…I'm a small Indian guy and I didn't look like a doctor and I'm in front of seven members, seven white members… I didn't even have my white coat. A doctor is known from his white coat and his professionalism but when you go to Congress, you don't wear a white coat. And being a foreigner, the insecurity is always there.[384]

Shah experienced his position as "foreign to the language of the courts, to the tribune of the tribunals."[385] This, Jacques Derrida writes, is the place where the foreigner is defined and located. It is the space where the foreigner is questioned and becomes a question for the tribunal to make pronouncements about. Shah managed his nerves and effectively articulated the grievances FMGs experienced while trying to doctor in the United States. He testified:

> A fully qualified psychiatrist and neurologists were told that a job [opening] was only for an American medical graduate…A radiologist who has served a hospital for over 10 years and has been considered by the hospital medical staff to become the chief, was told he could not be made chief because he is an FMG. A neonatologist's job as a department head was terminated because they wanted to hire a U.S. medical graduate to head the department.[386]

His testimony included studies showing FMGs provide comparable quality of care to their US counterparts, have less malpractice suits, less disciplinary actions, and receive a considerable number of Nobel prizes.[387,388]

Shah left the hearing feeling like legislators "really heard [him] because he spoke in a calm way with respect and facts and statistics and they felt sorry about the situation."

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[384] Dr. Navin Shah, interview with author, Potomac, MD, February 28, 2015,
[385] Derrida, *On Hospitality,* 15.
[386] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, 409.
[387] U.S. Congress, House, Committee on Energy and Commerce, *Hearing before the Subcommittee on Health and Environment: Health Manpower, 1988,* 100th Cong., 2nd sess., 1988, Shah,
[388] Dr. Navin Shah, interview with author, Potomac, MD, February 28, 2015.

He believed his testimony to be more impactful than the other FMGs who testified because they "were angry and just said we are good doctors but didn't come prepared with the facts." In drawing this distinction between his rational articulation and the emotionally laden, experiential register of his FMG counterparts, Shah reaffirmed the authority and privilege of a certain type of language or speech. He distanced from his colleagues by declaring their performance to be outside of the expected norms. "You can't talk like that," Shah remarked of his colleagues' testimony. In analyzing the place of the foreigner, Derrida explained the relationship of the foreigner to the language of the law. The foreigner "doesn't know how to speak this courtroom language, this legal rhetoric of accusation, defense, and pleading; he doesn't have the skill…the foreigner who, inept at speaking the language, always risks being without defense before the law of the country that welcomes him…the foreigner is first of all foreign to the legal language in which the duty of hospitality is formulated."[389] By emulating formal, legalistic language and norms of behavior practiced in the receiving country (the United States), Shah positioned himself as the appropriate intermediary and interlocutor, the one who is less foreign than the others and thereby most suited to present before the panel of "seven white members."

In spite of the best political efforts of FMG leaders and lobbyists, all three bills stalled in committee never reaching the floor for a vote. It turned out, that in "a shocking move" the "AMA House of Delegates voted to oppose the bills and lobby against

[389] Derrida, *On Hospitality*, 15.

them,"[390] reported *India Abroad*. The reason offered for the opposition was the "old states rights argument submitted by many a Southerner about federal regulation."[391] This position was confirmed in a letter between AMA executive vice president James Sammons and Congressman Jim Bates. In the exchange, Sammons wrote, "The AMA adamantly opposes discrimination against duly licensed physicians on the basis of ethnic or educational background. [However], we must oppose the bill because it would impose federal control over medical licensure. We believe strongly that the conditions for medical licensure should be set by the states. Each state is in the best position to determine what conditions are necessary to assure the health and safety of patients."[392]

AMA's political capital overwhelmed the efforts of the Alliance of FMGs and their Congressional sponsors. Both Solarz and Bates promised to renew their efforts during the next Congressional session. In the meantime, with the help of Senator Paul Simon from Illinois, they managed to add an amendment to the reauthorization of the Health Professions Act,[393] which "mandated an official study by the General Accounting Office of the problem of discrimination against foreign medical graduates who have already been licensed in one state and wish to relocate to another….The report required by the bill will examine the extent to which foreign medical graduates are forced to

[390] Ramesh Soparawala, "AMA to Lobby Against FMG Bills," *India Abroad*, December 25, 1987, 11.
[391] Dan Cook, "AMA Will Oppose FMG Bills Pending in Congress," *India West*, January 8. 1988, 1.
[392] Letter from James H. Sammons to Jim Bates, March 4, 1988, in personal archive of Navin Shah, Potomac, MD.
[393] Letter from Jim Bates to Charles Bowsher, Comptroller General of the United States, October 4, 1988, in personal archive of Navin Shah, Potomac, MD.

comply with overly burdensome licensing regulations and the extent to which they are victims of discriminatory efforts…"[394]

FMGs were now deeply entrenched into the world of American politics, fundraising, lobbying, rallying, and protesting for equal treatment "as true U.S. citizens," Kern Smith reminded them. He encouraged FMGs to "start waving the American flag [because] your rights are being denied to you."[395] During conversations with policymakers, however, one issue was continually raised, which was a distraction from the discrimination issue – legislators wondered why they should care about a "foreign" issue. FMG representatives expended energy explaining that foreign was a reference to their medical school, not their legal status in the United States.[396] Congressman Bates commented on the resistance he witnessed when he brought up the issue stating, "when you say foreign, it raises protectionist tendencies. It's not a politically popular thing."[397] There was a tension between the version of FMGs "as true U.S. citizens" and as *Foreign* Medical Graduates. Once again Bates explained, "Politics is emotions, not intellect. The emotions that are attached to this legislation have to do with the word 'foreign', which is a word that suggests we're not buying American."[398]

The idea of the foreigner provoked an imaginary that immediately separated FMGs, demarcating them outside of an ideological border. Although FMGs, especially

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[394] Letter from Stephen Solarz to Alliance of FMG leaders, November 2, 1988, in personal archive of Navin Shah, Potomac, MD.
[395] Letter from Kern Smith to Alliance of FMGs, May 14, 1988, in personal archive of Navin Shah, Potomac, MD.
[396] Shawn McMahon, *Fight for Equality*, 90.
[397] Charles Babbock, "Doctors' Groups Aid Lawmaker," *Congressional Quarterly,*
[398] Michel Potts, "Bates Claims FMG Bill Progress," *India West,* March 23, 1990, 41.

those who organized in the 1980s, were mostly full legal citizens or at the least permanent residents, their lived realities were structured by what Etienne Balibar calls the "heterogeneity" of borders, which exist in multiples for certain social groups.[399] The label of FMG, with an unknown origin predating these physicians, was challenging their demands for equality. If a group is willing to call themselves foreign, the logic followed that such a group must not be interested in joining the United States. Consequently, their grievances existed outside the juridico-legal apparatus of the State. It was a linguistic sleight of hand that allowed legislators to ignore the demands of FMGs. This is because the "foreigner, the foreign citizen, the foreigner to the family or the nation, is defined on the basis of birth; whether citizenship is given or refused on the basis of territorial law…the foreigner is a foreigner by birth, is a born foreigner,"[400] explained Derrida in "Foreigner Question." The status of outsider is a relation of birth and resists alteration even if the label of citizen is added. The new physical space, with a territorial law, cannot erase the fact of birth.

The liminal position of the FMG arose from their arrival, which was like that of a guest with terms structured by the law in a proscribed and limited way. The State or the host, as Derrida writes, has the power to receive choose, elect, filter, and select and when the invitation is given, there are certain rules of hospitality that are put into action on the part of the welcoming nation.[401] FMGs felt they were denied the rules of hospitality, the civil rights that should have been afforded to them based on their professional and legal

[399] Etienne Balibar, *Politics and the Other Scene* (London: Verso, 2002), 76.
[400] Jacques Derrida, *On Hospitality,* 87.
[401] Jacques Derrida, *On Hospitality,* 55.

status. Their phenomenological experiences resembled that of a parasite, or an intrusion, those individuals who cannot make a legitimate claim to the hospitality of the State.[402] To alter this conception, Shah and his lobbyists decided to change the name of the Alliance of Foreign Medical Graduates to the International Association of American Physicians (IAAP). International, they felt, "suggested a certain degree of sophistication" and it was strategic for an organization to be "American" while trying to lobby Congress for changes.[403] It was a reminder to the American public they experienced discrimination as *Americans* not foreigners. And under the *American* system, unfair treatment of *Americans* was unacceptable. Using the same logic, they replaced Foreign Medical Graduate with the phrase International Medical Graduate to emphasize their cosmopolitan, international origins rather than a dislocated, peripheral status associated with foreigners.

GAO Study and the 101st Congressional Session

The FMG bills were trapped in committees and no serious movement would take place until the Government Accounting Office (GAO) completed their investigation and report. The GAO's objective for the study was to assess whether FMGs faced unfair requirements for licenses to practice medicine, and the extent to which a lack of licensing reciprocity between states hindered FMGs' career prospects. Once again, Navin Shah took the lead on the project and met with the Chief Medical Officer of the GAO to better acquaint himself with the process. In his December 1988 report to the other FMG

[402] Jacques Derrida, *On Hospitality*, 59-61. ADD Steve Epstein, *Inclusion*
[403] Shawn McMahon, *Fight for Equality,* 90.

organizers, Shah enumerated the necessary course of action. The GAO granted a "request of one day of testimony by the leaders of the [FMG] community," and in preparation for this day, he asked members "to study licensing and reciprocity laws for each state, in order to search out any overt or covert areas of discrimination."[404] Shah ended the report with a request for the directors to ask their various communities "to send cases of discrimination directly to [him] with all the documentation."[405] Soon after, Hartke disseminated another letter emphasizing the urgency of the situation and the need for FMGs to find voice. He wrote:

> Your day before the GAO could be the deciding factor to bring success in our legislative endeavor to make this discrimination illegal. Don't let these greedy sources freeze you out of the practice of medicine…Unfortunately, not all Foreign Medical Graduates have felt the bitter taste of discrimination – YET! But I can assure you that the efforts of the greedy Medical Schools of the United States and Canada are working diligently to end the practice of medicine for Foreign Medical Graduates. Their biggest weapon against us is the SILENCE of Foreign Medical Graduates to defend themselves…The success of our legislative efforts will, in a large degree, depend on the report of the study by the General Accounting Office.[406]

Hartke's rhetorical flourishes and stereotypical portrayals of the silent immigrant achieved the desired effect. Shah was quickly inundated with cases of unfair treatment. When FMG leaders were called to testify before the GAO on May 8, 1989, Shah, as the leader of the contingent, was prepared with 85 comprehensively documented cases of

[404] Letter from Navin Shah to IAAP Directors, December 19, 1988, in personal archive of Navin Shah, Potomac, MD.
[405] Letter from Navin Shah to IAAP Directors, December 19, 1988, in personal archive of Navin Shah, Potomac, MD.
[406] Letter from Senator Vance Hartke to Navin Shah and Directors of FMG groups, December 29, 1988, in personal archive of Navin Shah, Potomac, MD.

discrimination.[407] His testimony enumerated the types of discrimination FMGs faced such as denial of hospital privileges, lack of promotions, inability to move between states, and ended with a request for a central repository where FMGs could deposit their documentation including school transcripts, recommendation letters from professors, and various other data regarding their medical education, one time.[408] These documents would then be authenticated and readily accessible for the purposes of obtaining hospital privileges and licenses in the event of an employment relocation without delay. Shah concluded testimony by reminding the audience that FMGs are interested in "one standard to judge the professional and ethical conducts for both Americans and foreign medical graduates. This would eliminate the two tier system which is presently practiced, and puts foreign medical graduates at a great disadvantage."[409] In his statements, despite FMGs self-reflexive move to change their classificatory label to FMGs, Shah continued to refer to himself as foreign and differentiated between "Americans" and foreign graduates as if these categories were mutually exclusive. Overall, FMG leadership, pleased with the GAO testimony, felt optimistic that the report would convince Congress to pass the latest bills Bates and Moynihan reintroduced during the 101st Congressional session in favor of equal treatment.

The GAO report was scheduled for release in August of 1989. When this date passed Hartke was irate. He wrote to the GAO expressing frustration at the perpetual

[407] Foreign Medical Graduate Discrimination Cases, prepared by the Hartke Law Offices, August 1989, in personal archive of Navin Shah, Potomac, MD.
[408] Aziz Haniffa, "Central Data Bureau Set for FMGs," *India Abroad,* September 8, 1989, 32.
[409] Government Accounting Office Testimony by Navin Shah submitted to the IAAP leadership, May 8, 1989, in personal archive of Navin Shah, Potomac, MD.

delay because "they were informed that the report would be ready in October, then November, then in January [1990], then in February or early March."[410] Hartke investigated the delay through his connections uncovered the following, "AMA lobbyists claim that they are responsible for the delay… and are saying that they have been able to delay the report until April or even later."[411] Furthermore, Hartke learned "AMA lobbyists were publicizing the fact that they "convinced the GAO to provide a very weak report about the issue…[they] claim they have an agreement with the GAO that the term 'discrimination' will not be contained in the report. They claim that the GAO has agreed to use words, which are much softer…. If the GAO admits there is discrimination but fails to label it as such in its report, then the entire study becomes an exercise in futility."[412]

On March 1, 1990, Hartke sent another letter to the GAO office admonishing their lack of impartiality and expressing his dismay at the GAO's choice to excise the word "discrimination" from the final report replacing it with "difference". He wrote: "You said that you did not consider the absence of the use of the word 'discrimination' as meaningful. To the contrary the lack of that word is very meaningful. The distinction between 'difference' and 'discrimination' is significant. Discrimination is in the category of prejudice, bias, intolerance, and bigotry. Difference is in the category of variation or

[410] Letter from Vance Hartke to Murray Grant, General Accounting Office, February 13, 1990, in personal archive of Navin Shah, Potomac, MD.
[411] Letter from Vance Hartke to Murray Grant, General Accounting Office, February 13, 1990, in personal archive of Navin Shah, Potomac, MD.
[412] Letter from Vance Hartke to Murray Grant, General Accounting Office, February 13, 1990, in personal archive of Navin Shah, Potomac, MD.

dissimilar…The AMA wants a white wash and they are convinced they will get it."[413] Hartke condemned them for allowing the AMA to get away with this and use what he called the "separate but equal" argument.[414] Hartke pushed for the invocation of discrimination over difference because in US political and legal discourse, discrimination had the potential to catalyze a particular course of action. Within the post-racial liberal democracy, to have vestiges of a "separate but equal" system was an affront to democracy and impossible for legislators to ignore. It required redress in a structural, or institutional capacity. Difference, however, as "variation or dissimilar" could simply exist within the locus of the interpersonal and attitudinal. Difference was extrajudicial and could be tolerated within the confines of the law. The presence of difference, to a certain limited degree of course, was expected to exist.[415] Hartke's final accusation of the white washing can be interpreted in two ways: by denying the discrimination FMGs experienced, organized medicine wanted to cover over, to white out, the problem and ignore the mistreatment experienced by a quarter of the physician labor force. And secondly, by ignoring the complaints, FMGs would remain marginal to the phenotypically white center of organized medicine in America. When the GAO report was finally released in May 1990, discrimination was nowhere to be found in the text.

Between 1990-1992, there was nominal interest in the FMG cause, but momentum had largely shifted. Senator Paul Simon introduced the International Medical

[413] Letter from Vance Hartke to Murray Grant, General Accounting Office, March 1, 1990, in personal archive of Navin Shah, Potomac, MD.
[414] Letter from Vance Hartke to Murray Grant, General Accounting Office, February 13, 1990, in personal archive of Navin Shah, Potomac, MD.
[415] Letter from Vance Hartke to Murray Grant, General Accounting Office, March 1, 1990, in personal archive of Navin Shah, Potomac, MD.

Graduates Anti-Discrimination Act in 1990, which never made it out of committee. Senator Moynihan's Equal Opportunity for Medical Licensure and Reciprocity Act had a similar fate. The House bills reintroduced by Bates and Solarz stalled in committee. However, the outcome was not all bleak. Elements of Simon and Solarz's legislation made it into the Health Professions Reauthorization Act of 1992. The final bill contained three provisions aimed at addressing unequal treatment of FMGs. It established an advisory committee responsible for making recommendation on non-discriminatory licensing procedures. It mandated a Health and Human Services study of difference in licensing for FMGs and US graduates in ten states. And the bill stated that federal funding would be denied to any residency training program that discriminated against FMG applicants.[416] Although this legislative success was small, for Navin Shah, "once the bill was passed, [he] was done."[417] He reflected on the "fight for equality" explaining, "it was a climax as well as an anticlimax. The climax was that we got a bill passed and the anticlimax was the demolition of the whole structure that we created. Everybody [in IAAP] separated. If only we had another five years…"[418]

Becoming Bureaucracy: The Archive and Self-Making

Shah began collecting discriminatory characterizations of FMGs printed in newspapers and medical journals starting in the 1970s and continued until passage of the Health Professions Reauthorization Act of 1992. His systematized collecting included innumerable correspondences, vast amounts of print material, and nearly every published

[416] Shawn McMahon, *Fight for Equality*, 131.
[417] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.
[418] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.

study and governmental hearing related to FMGs in the United States during those years. He became the mediator between 180,000 FMGs, the State, and organized medicine by managing and interpreting the paper lives of FMGs and their grievances and adapting this information so it would resonate in a new context.

It was incumbent upon Shah to acquire and embody proper bureaucratic logics. He curated, classified, categorized, judged, and annotated the reference library in a systematic way. As Max Weber explained, "This bureaucratic management was the "means of transforming social action into rationally organized action."[419] "Bureaucracy is and was a power instrument of the first order for one who controls the bureaucratic apparatus."[420] The importance of knowing the system was expressed repeatedly as well as the shortcomings of those who were hasty and unfamiliar with the "way to do things." The existence and volume of the archive imparted *him* with a particular knowledge that was unique and increased *his* overall credibility. Shah explained his relationship to the "way to do things":

> It's like a shayar [a special kind of poem]. It's its own decorum, its own formation, its own rules and regulations. So same thing in Congress, there is a system of work, a system of conversation...so all these people that had no experience went and talked all of this nonsense. They didn't have the proof. Fortunately, I had some papers to show that…When you have to get the work done, there is a system, there is a discipline…there are a lot of steps…So all this time I kept the records because I was doing all the work.[421]

While Shah was the archivist and gatekeeper of the documents, his actions and decisions are inflected with a cognitive process of classifying that mirrored bureaucratic structures.

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[419] Weber, *Economy and Society*, 987
[420] Weber, *Economy and Society*, 987.
[421] Dr. Navin Shah, interview with author, Potomac, MD, February, 28, 2015.

His choices about what to collect and how to preserve the FMG narrative in a way that was legible to the "system" and contained a "discipline" suggests the importance of self-making through bureaucracy. Shah enacted the idea that "rationally organized and directed action is superior to every kind of collective behavior."[422] He constructed FMGs' paper lives through these logics, having "some papers to show" that FMGs were not subpar and following all of "the steps." Shah fashioned himself and the collective he represented in a way that depended on knowing and understanding the importance of bureaucratic operations within a modern, liberal system of governance. His subjectivity in the US, which was created and instantiated through bureaucratic regulation, was now internalized through the process of documentation and archiving. In this way, "he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection"[423] and produces himself as a bureaucratic subject. When working with his files, Shah is particular about his method of organization and unique assemblage of documents, or the form of his archive. By appropriating the form of the archive, he mimics this state practice so as to elevate the authoritative significance and importance of his collection. These archival practices, traditionally relegated to the realm of the state or state-like bureaucratic institutions, structured his sense of self. Shah imitated and reproduced bureaucracy in such a way that he saw himself in the documents and the archive he created. Document collecting, categorizing, and archiving was an important self-making process as it reflected both a biographical past as well as invoked a future political imagination. It was a way to author a narrative;

[422] Max *Weber, Economy and Society*, 987.
[423] Foucault, *Discipline and Punish*, 203.

it was a method "colonized people use to assert their own identity and the existence of their own history."[424]

Embodying the office, becoming the reference library – it is in these actions that Dr. Shah became like a state. By mimetically deploying institutional logics in his own collecting practices, he created an archive to legitimate his prominent role in the FMG cause and to concretize a collective identity. He vernacularized this state practice with the intention to negate the deprecatory impression of FMGs prevalent within organized medicine. Vernacularization as defined by Peggy Levitt is "the process of appropriation and local adoption of globally generated ideas and strategies." People who do the work of vernacularization operate such that they can be "conversant with both sides of the exchange." By embodying the office, Shah was able to occupy this position.

This archive project was a way to build a script and define a course of action for future political reference. Although Shah states that discrimination was "very little" and basically a moot point, his unwillingness to relinquish his collection suggests otherwise. Within the documents, Shah has charted out the requisite steps for political action. When he embarked on his project, he was a newly arrived novice in regards to the American political process. This work forced him to decipher and negotiate in a way that facilitated particular insights about "how to get things done." Shah elaborated: "It's an exercise on how to get a bill passed. I can write a book on that."[425] "You have to "convince a [congressperson] to take up your cause. First of all you must introduce the bill, get a

[424] Edward Said, *Culture and Imperialism* (Vintage, 1994), *xii*.
[425] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.

congressmen on board who is in power and believes in the cause himself…and get all the people from a state to call their congressman… then you meet with the committee and make sure that the bill gets marked up. It's a very tough procedure. Then there's a testimony…if the whole committee agrees and there isn't much controversy, it goes in a packet of bills."[426]

Shah's familiarity with the political system came by way of hiring lobbyist (using his own funds at times), flying around the country to garner support for his cause, multiple meetings with the AMA and other governmental bodies, Wednesdays on Capitol Hill in the hopes of running into someone important, and countless hours of phone conversations with other FMGs to convince them of the importance of the cause. Being able to navigate the relatively opaque political system gave Shah a political, procedural sensibility that could be called upon in the future if necessary. Holding onto his papers, structuring his archive in a particular way – these actions suggest an anticipatory quality to his archive that belies his pronouncements that the work was done and that discrimination was over. It reveals tenuousness and an incompleteness in his relation to the idea of "equality" as this archive maps out a course of action for "what might be needed next time." He explained, "I never threw away anything because I might need it next time and I have to have a reference" and "When the bill was passed, that was the end of the story for me," are illustrative of the anxieties and contradictions ensconced in the archiving project. Although the event that the archiving was assembled for passed, his reference to the "next time" gestures towards two future possibilities: the "fight for

[426] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.

equality" is incomplete and the archive is a potential site of recognition for his unacknowledged political work.

Although this archive was catalogued and collected by one individual, there is a yearning for a collective enmeshed in the boxes. In taking archives seriously as "complex social organizations"[427] and "the product of the anticipation of collective memory,"[428] I suggest that this collection is a place where Shah constructed a collective identity in the struggle. In spite of repeatedly alluding to his singularity and in-group discrimination during the "fight for equality," the nature and volume of his papers became a way to create connectivity and document dialogue. The preservation of every correspondence, however mundane, or the photocopying of a letter multiple times underscored his position as a "representative of 180,000." The materiality of the documents represented the voices of the collective. By amassing them in one location, he was able to view himself as part of a national conversation with FMGs fighting for equality.

In his process of vernacularizing bureaucratic practice, Shah assumed a position of power as well as vulnerability. As a primary site of data collection, he was given an authoritative, leadership position within the FMG community and instrumentalized by others for his ability to operate as a central repository. However, as is often the case in any collectivizing effort, there were suspicions concerning his true motivations. Some in the FMG movement understood Dr. Shah's hold on documents and information as a manipulative tactic deployed to ensure his primacy in the FMG organizing efforts. He

[427] David Zeitlyn, "Anthropology in and of the Archive: Possible Futures, and Contingent Pasts, Archives as Anthropological Surrogates," *Annual Review of Anthropology* 41(2012), 466.
[428] Stoler, *Along the Archival Grain,* 16.

recalled: “Many people tried to put me down. It was survival. I was doing the work and people are putting me down. And then they are putting other people in the position so then I have no position. But then I have to go to Congress and all that and follow it up and I had some title every time and I had to answer to them and they would not know.”[429] Shah continued to explain that the “other people who were put in the position” lacked procedural knowledge he acquired by attending to details and meticulously collecting documents over many years. His personal archive was a rebuttal to those “putting him down.”

Shah experienced a lack of recognition from his peers, a vital human need, as Charles Taylor explains. His archive operated as a proxy for public recognition during the 1970s and 1980s and an aspirational site for future recognition. When discussing future plans for his collection of documents, Shah responded, “I don't know who will be interested…I never thought anyone would right a book [Fight for Equality book reference]…or that anyone would write a thesis about it [this dissertation].” Nevertheless, he managed this collection for approximately 35 years implicating a future audience in the construction and maintenance of the archive. The documents, which were assembled for a prior objective, could be requisitioned to write a new narrative. Mimicking state practices of data collection established his authority in a past moment and preserved an image of self into the future through this very archive. By producing the archive in a way that resembled “official” archives, Shah wrested power away from the “official” archive as he felt it misrepresented FMGs. His isomorphic version of an archive could argue

[429] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.

against, disrupt, and potentially replace the "official" one that opposed FMGs and understood them as "second rate doctors [whose] education as [organized medicine] projected was third rate."[430] It was a site through which to rectify misrecognition and correct the psychological harm that imprisoned FMGs "in a false, distorted and reduced mode of being."[431]

Nearly 25 years after the International Association of American Physicians won their "fight for equality," Shah's basement remained stacked high with boxes of yellowing documents from that period, representing years of his life's work. When asked why he started to compile documents, Shah answered by explaining he had to become the office and the reference library:

> There is no office. I was in charge and I was the office...I was a reference library. That's why I collected. In a way it was good that I kept all the papers. It was a big house so storage was not a problem. I spent so much time, so much money, so much energy, and so much emotional, because up and down kafi hota hai ismay [there is a lot of that in this] and then it becomes your personal thing…I didn't take much interest in the children, education, everything my wife did so I had the time. I got too much involved… eventually what happened is that I never threw away anything because I might need it next time and I have to have a reference. This became like a full time job. Once I took it, I got more and deeper and deeper…I was really very deep inside. We didn't have an office, and so I became the office and collected all that…I never threw it away because it was monumental work and my heart was still there.[432]

In *The Politics of Recognition,* Taylor writes, "the formation of identity and the self as taking place in a continuing dialogue and struggle with significant others" in the private sphere.[433] For Shah, this struggle in the private sphere was made manifest within

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[430] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.
[431] Fanon, *Black Skin, White Masks*, 18.
[432] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.
[433] Taylor, "Politics of Recognition," 37.

his collections. When discussing his archive and the reasons for collecting, there is a dissolution of the boundary between the personal and the political. During the period when he was doing the majority of his collecting, Shah recounted that his children expressed disappointment over his lack of involvement with them. He recalled only being present for "father-daughter dances and school plays." This project became "like a full time job" in addition to his job as a young physician. Shah "would get home after work and have dinner and then by eight o'clock, this session would start." Being "very deep inside" the FMG situation required his absence from familial rhythms and markers.

The creation and maintenance of this personal FMG archive could be seen as a desire to produce a sense of fixity of biographical time during a period when Shah stated he "missed out on all of the family things" because he was "very deep inside." Because the personal felt dislocated, Shah produced stability and order in the archive project, which was at its most robust with massive amounts of missives and clippings. His documents, many of which bore official stamps and signatures from figures such as Senator Daniel Moynihan or Senator Paul Simon or were articles published in news outlets in which he was referenced, replaced his relations in the private sphere.

In Shah's willingness to devote the remainder of his post-official employment time to the practice of collecting and archiving, I identify a displacement of affective longing and sentiment that becomes memorialized in these documents. His reference to the excess of "emotional up and down" highlights an important dimension of archival construction that is often excised from the historical record for the purposes of

maintaining bureaucratic rationality. "Sentiment is the negative print" of the archive.[434] These carefully constructed and cultivated artifacts bear witness to the entanglement of bureaucratic practice and the emotional registers of home and family. It is exemplified in Shah's contradictory statements of being done with these documents after a certain period of time, yet having the space to keep them in his home and preserving them "because it was monumental work and [his] heart was still there." [435] His archive in relation to his biographical time suggests a longing for a previous irretrievable moment and the materiality of these boxes physically grounds this sentiment within the space of his home.[436,437]

Shah's self-identification as the office or the reference library highlights an important site of modern subject formation. Legal entry, legibility, and permissibility: these techniques of control depend largely on bureaucratic logics and managements strategies, foremost being files and cases. Organizational structures allow for a concentration of informational capital and writing and archiving are instruments through which this information is aggregated and concentrated. For Bourdieu, the archive is an expression of governmental control as it makes manifest the symbolic power of the state in "the form of specific organizational structures and mechanisms" which are then translated into "mental structures and categories of perception and thought."[438] Bureaucratic communication and procedure inscribe a particular vision and way of being

[434] Stoler, *Along the Archival Grain,* 101.
[435] Dr. Navin Shah, interview with author, Potomac, MD, September 19, 2015.
[436] Ann Stoler, *Along the Archival Grain*, 101.
[437] Heimer, "Conceiving Children,"104.
[438] Pierre Bourdieu, Loic Wacquant, and Samar Farage, "Rethinking the State: Genesis and Structure of the Bureaucratic Field," *Sociological Theory* 12(1994): 4.

on the mental structure of the liberal subject.[439] Even as the external conditions of control are removed, a liberal subject will have internalized the structuring logics and self-police in such a way as to ensure their own compliance with ideals and expectations. Foucault commented on this process in *Discipline and Punish*: "The efficiency of power, its constraining force have in a sense passed over to the other side – to the side of its surface of application. He who is subjected to a field of visibility, and who knows it, assumed responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribed in himself the power relation in which he simultaneously played both roles; he became the principle of his own subjection."[440] In the case of Shah, this form of internal discipline and subjectification mimicked bureaucratic form and discourse. As such, archiving became an important practice necessary to produce a particular vision of a liberal self with the possibility of achieving public recognition. This way of archiving is a departure from a personal or familial archive as it was intended to institutionalize a collective memory and enable a particular performance as a political subject.

As "the office," archiving becomes an important practice, as "there is no political power without control of the archive."[441] Shah constructs and curates his archive as a way to subvert the system that produced and characterized him and his collective as "second rate doctors". However, through the process of archivization, he assumes the role of a

[439] Bourdieu et al., "Rethinking the State," 7.
[440] Foucault, *Discipline and Punish*. See also Judith Butler, *Psychic Life of Power: Theories in Subjection* (Stanford: Stanford University Press, 1997).
[441] Jacques Derrida, *Archive Fever: A Freudian Impression* (Chicago: University of Chicago Press, 1998), 4.

bureaucratic authority and usurps bureaucratic discourse for his own production of biography. In so doing, Dr. S upheld the system and logics that are implicated in producing his subjectivity; "the archivization process produces as much as it records the event."[442] The process of creating the archive is a way of validating and agreeing with the legitimacy of the established order by seeing it as the objectively, natural way to exist and act and it is this agreement that connects the bureaucratic order to the unconscious.[443] Shah became the office because he saw the office at the only way to be. His way of accessing the liberal recognition that is withheld must occur within signs, symbols, systems, and discourses that are external to him. In his process of trying to create a counternarrative to the discriminatory one perpetuated in the public sphere, his archive produced him in the image of a modern bureaucrat as described by Weber. There is a clear jurisdictional area that he officiates and within this domain, assumes the role of monocratic authority. His way of establishing this authority is through informational capital and more explicitly, the collection of files and documents.[444] The creation of this archive was oriented towards deciphering a system of rules and establishing a course of action in accordance with procedural norms. In this archiving process, biographical memory and political history are inextricably connected.

Conclusion

Shah's basement is a repository for documents, an archive in his home. Boxes are neatly curated and organized adhering to the form of an archive. File cabinets overflow

[442] Derrida, A*rchive Fever*, 17.
[443] Bourdieu et al., "Rethinking the State," 14.
[444] Max Weber, *Economy and Society*, 956-958

with hundreds of copies of his GAO testimony and clippings from newspapers no longer in circulation. This library, housed in his home, contains the history of the *Fight for Equality* and Shah's biography. The two overlap in these documents. In "Cultural Identity and Diaspora," Stuart Hall explains the work of images in identity formation. He writes, "images offer a way of imposing an imaginary coherence on the experience of dispersal and fragmentation."[445] In Shah's archive collection, Hall's observations ring true. The archive is a potential site to ground the dislocation of diaspora. When Shah began AAPI in the mid 1970's, he was primarily motivated by the desire to provide a cultural space for his children to connect with the home he left behind. The political work was coincidental; it was an unexpected "matter of destiny." Nevertheless, he invested heavily in the "fight for equality" because" right is right." Along with a few other physicians, Shah and his colleagues organized a sizeable Alliance of predominantly Asian FMGs into a political group willing to make demands publically. No longer the injured and voiceless as their lobbyist Vance Hartke characterized, these physicians protested on the steps of Capital Hill.

However, a question remains -- how did the Alliance of FMGs (later the IAAP), which included groups from other Third World nations, become a story largely involving South Asian FMGs? Certainly source choices and the fact that India was and continues to be the largest physician sending country influenced the narrative in this particular way. However, the effects of a historically "nostalgic" relationship to the Indian subcontinent and the influence of ethnic newspapers should not be underestimated. While Navin Shah

[445] Stuart Hall, "Cultural Identity and Diaspora, *"Identity, Community, Culture, Difference,* ed. by Jonathan Rutherford (London: Lawrence and Wishart, 1990): 224.

was certainly a central figure in the FMG political project, alongside him was Aziz Haniffa, a journalist for *India Abroad*. This newspaper, which claims to be the oldest and the most widely circulated Indian related weekly in the United States, reported extensively on the FMG situation. Shah recalled, "Aziz always came with me. He gave us all of the help."[446] Aziz Haniffa corroborated this saying: "When I was writing, the message was being disseminated on a national scale [because many South Asian doctors had lifetime subscriptions to the paper]. I was educating them what legislation was all about and how the whole process worked. It was advocacy journalism.[447]

In addition to the political work of Shah and his colleagues, South Asian physicians could rely on advocacy journalism as a tool to educate and mobilize the community. Haniffa, now the editor of *India Abroad,* stressed this point when recounting the story of Vivek Murthy's stalled confirmation hearing for the position of Surgeon General. Murthy, a first generation Indian-American born and educated in the United States, caused un uproar due to his stance on firearms. With pressure from the National Rifle Association, Congressional Republicans aimed to block his confirmation. And Democrats, with Harry Reid leading, were unable to persuade them otherwise. In January 2015, Reid's term was ending and a Republican was going to replace him. "There was no way they would confirm Murthy," explained Haniffa.[448] Something had to be done quickly. He continued:

[446] Navin Shah, interview with author, Potomac MD, February 28, 2015.
[447] Aziz Haniffa, interview with author, Washington DC, September 19, 2015.
[448] Aziz Haniffa, interview with author, Washington DC, September 19, 2015.

> I wrote an editorial in the paper and even called out names of Indians and wrote 'where are you guys?!' A guy in Harry Reid's office said you wouldn't believe after that the number of calls and emails that came into the office. And then Harry Reid took it up and [Murthy] was confirmed at the last minute…I have emails from Vivek saying if it wasn't for you Aziz [Haniffa], I would never have gotten confirmed."

Murthy was confirmed on December 15, 2014, just a few days before the Congressional winter recess. In Haniffa's estimation, "It was the beginning of kind of political empowerment."[449] With the help of the ethnic newspaper and the increasing political presence of the community, the South Asian physician began to disaggregate from the foreign physician conglomerate. This cohort of immigrants persuasively combined a fetishized colonial past as the "jewel in the Crown" with a prestigious and relatively affluent profession. Embodied in this form, the South Asian physician became a "brand" with a notable presence in mainstream cultural spaces. In the final chapter, I explore the rough contours of this brand, paying attention to the economic and cultural factors that has permitted South Asian physicians, immigrant and first generation, to occupy a normalized, almost unremarkable presence in American media.

[449] Aziz Haniffa, interview with author, Washington DC, September 19, 2015.

CHAPTER 5: BRAND PLACEMENT

Aziz Haniffa, a Sri Lankan born immigrant to the United States and the current editor of *India Abroad,* explained his journalistic commitment to the IMG cause in the following way:

> The thing is that the South Asian doctors really are the brand of the community. It's only later that the motel owners and the IT guys showed up…and the fact that some Congressman or their family member was being treated by an Indian doctor helped… They started learning how government works and branding went hand in hand with increased political involvement.[450]

His usage of the word brand directly implicates the economic aspects of "increased political involvement." This was obvious to Representative Stephen Solarz of New York, referenced in the previous chapter, the self-proclaimed representative of Indian physicians. The positive branding and commodification of the South Asian foreign physician was rooted in the political economy of this practitioner. The timing of their migration, having a marketable identity, and the intimacy of care work contributed to their marked inclusion into cultural spaces over the last few decades. The "South Asian doctors really [became] the brand of the [South Asian] community." The trend began with political branding of the South Asian IMG and has been consolidated in representations of first generation South Asian-American physicians today.

Brands are produced in the realm of imagination. They collapse individuals and generalize experiences to narrate and promote ideal types erased of messiness. In this chapter, I begin to outline the contours of the South Asian physician as a commodifiable

[450] Aziz Haniffa, interview with author, Washington DC, September 19, 2015.

brand. The IMG's economic position is taken as the foundational starting point for this argument. Because of the geographical mobility afforded this immigrant group via their profession, South Asian physicians have been able to grow their wealth and prestige, gaining admission into the realm of the upper middle class and upper class. Entry into these strata not only signaled their commensurability with the liberal ethos of the United States, it also inhered a morality and value to their persons. The next section explores other large South Asian labor communities such as the IT worker, the motelier, the scientist/engineer and the taxi driver. These groups have failed to occupy the same recognized and respected profile as the South Asian physician either due to their class position and/or the nature of their work, making them less amenable to market consumption. The final section analyzes exceptional representations focusing on two examples, Deepak Chopra and Abraham Verghese. In the early 1990s, these exceptional figures eased the South Asian physician into the mainstream imagination. Their breakthrough positions allowed second generation South Asian physicians entry into the mainstream in the person of CNN Chief Medical Correspondent Dr. Sanjay Gupta, Surgeon General Dr. Vivek Murthy, Surgeon and New Yorker contributor Dr. Atul Gawande, and the fictional persons, Dr. Mindy Lahiri of *The Mindy Show*, Dr. Neela Rasgostra of *ER,* and Dr. Lawrence Kutner of *House* -- the effective consolidation of the brand.

The role of mass media in shaping subjectivities should not be overlooked. As Kamari Clarke shows, mass media is an important site through which to conceive of

different versions of diaspora.[451] In Ethnicity Inc., Jean and John Comaroff's further elaborate on this process to show marginalized groups produce themselves in commodifiable forms in order to gain market legibility. Ethnicity becomes the new mode of production.[452] Their insights are projected onto the big screen with the collection of essays in *The Colorblind Screen: Television in Post Racial America*.[453] Using the insights of these scholars, I question the rise and ubiquity of the South Asian physician form in the media. During the same time that there has been a rise in hate crimes and hate speech against non-white, "foreign" bodies, there has been a concomitant presence and acceptance of the South Asian physician in mainstream imagination. In this realm, the South Asian physician has escaped the homogenizing discourse of xenophobia and terror that mark the present. I suggest that the South Asian physician escaped by virtue of their care work and the trust inhered in their professional position. As Jean and John Comaroff explain in *Ethnicity, Inc*. in relation to identity and ethnicity, if there is nothing "*dis*tinctive" to alienate or promote, there exists the possibility of "*ex*tinction."[454] The distinctive act of treatment diminished the impact of their foreignness. In this role, the moral valence of skilled care work and the intimacy associated with it, allowed the formation of a positive South Asian physician identity that could be tolerated within a liberal multicultural democracy.

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[451] Kamari Clarke, "Mapping Transnationality: Roots Tourism and the Initialization of Ethnic Heritage," in *Globalization and Race: Transformation in the Cultural Production of Blackness* ed. Kamari Clarke and Deborah Thomas (Durham: Duke University Press, 2006), 143-144.
[452] Jean Comaroff and John Comaroff, *Ethnicity, Inc*. (Chicago: University of Chicago Press, 2009).
[453] *The Colorblind Screen: Television in Post Racial America* eds. Sarah Nilsen and Sarah Turner (New York: New York University Press, 2014).
[454] Comaroff and Comaroff, *Ethnicity, Inc*., 10.

Mobility and Wealth

The early 1990s and 2000s witnessed the maturation of South Asian physician communities. While new IMGs working as interns and residents were continually arriving, the first wave of elite migrants settled in, building permanent lives. Taking the clinical skills and training acquired in many inner city and rural communities, the earlier IMGs leveraged this knowledge to establish lucrative private medical practices, which in turn facilitated a social class transformation. The most common trend was an out-migration from the city to suburban communities where there was a significant increase in earnings potential. Although this internal migration was not unique to IMGs, the geographical transition of practitioners was continually raised as a causal factor in the perpetual doctor shortage crisis. David Rosner marks this transition even in the early days of the profession at the turn of the twentieth century. As wealthier individuals migrated to the suburbs, Rosner writes, "often local practitioners joined with the professional and white-collar workers in this move to the suburbs." He continues to explain that this resulted in working class groups finding themselves "without the doctor."[455] Nearly a hundred years later, the problem remains. Attempts at incentivizing the redistribution of physicians or altering compensation structures were never effectively legislated or implemented.

Dr. Donald Dewey, a professor of Urban Geography at DePaul University in Chicago, conducted a study analyzing the internal physician migration in the Chicagoland area between 1950-1970. He identified factors, which prompted the movement of

[455] David Rosner, *A Once Charitable Enterprise,* 37.

physician from the city proper to suburban communities. These included "variation in the socioeconomic status of an area, the proportion of blacks living in the community, and the age of the physician,"[456] to name a few. Dewey concluded:

> In spite of the gain in the total number of doctors between 1950 and 1970…Chicago's current physician population ratio is the lowest in the city's history and is expected to establish new record lows every year for the next 2 years [a 35 percent decrease]…The suburbs, on the other hand, gained over 1,900 doctor's offices and increased their physician population ratio…Suburban areas of high socioeconomic status gained a disproportionately high share of the shifting doctors [an over 130 percent increase], while the poor and black areas of the city lost more than their share of doctor's offices…the average age of physicians and the proportion over 65 years old in the poverty areas, areas undergoing racial change or which had high proportions of black population, all rose substantially while the average age of physicians in affluent, predominantly white suburban areas declined sharply with the proportion of M.D.'s under 45 years old rising rapidly.[457]

Dewey went on to argue that this trend is not unique to Chicago and is in fact occurring in all major cities. His findings were supported by another study undertaken by Professor Pierre de Vise in which he determined: "When we look for explanations for [the] huge differences in community physician-population ratios [between suburbs and the city], two and only two variables stand out – average personal income and population density."[458] These studies underscored a major problem with the healthcare system; maldistribution of physicians was just as much, if not more, of a contributing factor to doctor shortages as the actual number of available physicians. A study of the cardiology workforce between 1995-2007 confirmed this observation showing cardiologists were disproportionately

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[456] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 485.
[457] U.S. Congress, Senate, Committee on Labor and Public Welfare, *Hearing before the Subcommittee of Health: Health Manpower, 1974,* 93rd Cong., 2nd sess., 1974, 485-487.
[458] Pierre de vise, "Health Planning in Illinois: Physician Needs for Illinois in the 1970s," *Illinois Regional Medical Program* 2(1971): 4,

concentrated in affluent communities across the country.[459] Although statistical data on the suburban practice of IMGs in particular is unavailable, it is logical to assume based on their numbers in the workforce and through oral histories, this suburban migratory trend was also prevalent amongst IMGs.

Credentials facilitated IMG mobility, making porous the often intransigent boundaries between urban and suburban communities. Dr. AA made this transition early on in his medical career. In 1969, he completed his intern year at Cook County Hospital in Chicago and decided to pursue a hematology/oncology residency. His career choice was inspired by a "Hispanic young man who had lymphoma, received chemotherapy at the hospital and went into remission."[460] This individual, like many other non-white, low-income patients who frequented the public hospital, presented with a complicated case, "ideal for learning," Dr. AA said. Inspired and intrigued by this case, he presented it at grand rounds and committed to the specialty. He secured a residency position at Cook County and upon completion, continued as an attending "while deciding what to do next." At the end of 1974, he relocated to a wealthy, predominantly white suburban community both for personal and professional reasons. Dr. AA remarked on the transition in regards to his relationship with patients: "in Cook County, once the patient meets you as the doctor, they quickly accept you and it's all ok…but it was different in the suburban practice. I quickly found that people were more discriminating and racist. You could sense their discomfort. But as time went on, slowly these things disappeared…but mostly

[459] S. Aneja et. al, "US cardiologist workforce from 1995 to 2007: modest growth, lasting geographic maldistribution especially in rural area," *Health Affairs* 30(2011): 2301-2309.
[460] Dr. AA, interview with author, Illinois, July 23, 2015.

because the next closest hematologist was at the University of Chicago [a considerable distance away]. When you're a physician and you have some skills, then they have no choice." Although Dr. AA was reluctant to describe his move to the suburbs as a purely economic decision, the consequence of the move had undeniable economic advantages.

Not only was the work more demanding in shortage area communities, structures of reimbursement in the form of physician fee schedules also incentivized out-migration. Physician fee schedules are calculated using three pieces of data: physician work, practice expense, and malpractice insurance. In 1992, the Center for Medicare and Medicaid added a geographic practice cost index component to this formulation to adjust for location specific cost differentials. While valid for real estate and rents, physician work and wages also fell into this variable category. The calculation of wages was based on the average salaries of six proxy health and non-health related occupations in the geographic area, making salaries also location specific. Critics of this system pointed out, "physicians should not be compensated for their time differently based on where they live."[461] The result is that physicians working in poor communities or rural areas are compensated less than physicians working in upper class urban or suburban locales. This financial schematic often disincentivizes foreign physicians from remaining in the communities where they trained. Congressman Nick Smith clearly and bluntly explained the problem saying, "Individuals that can get a 10 percent higher salary in one area compared to another are going to [get it]…Wage indices tend to be self perpetuating. The [suburban] hospitals receive higher than average reimbursement form Medicare and so

[461] U.S. Congress, House, *Hearing before the Subcommittee on Ways and Means: Medicare's Geographic Cost Adjustors,* 107rd Cong., 2nd sess., 2002, 11.

can offer higher wages and salaries."[462] Hospitals in urban, poor communities operated at a disadvantage due to the geographic wage index and consequently lost physicians, ensuring perpetual shortage and crisis.[463]

For those IMGs who began their careers in rural shortage areas, an alternative mobility route was from rural hospitals to suburban private practice. Dr. B began his medical career in a town an hour from Tuscaloosa, Alabama. He arrived during the 1980s when immigration tightened due to the perceived doctor surplus explained in chapter 4. His modified J-1 visa stipulated that in order to convert the temporary visa into permanent resident status, Dr. B was required to complete at least 3 years of medical service in a rural community. He arrived to work in a "laid-back sort of town, low tempo, very small," with a patient population that was predominantly "very poor black farmers" who treated him with "a lot of respect."[464] Dr. IB explained, "those people were so poor, they don't have any access to doctors so they were very thankful and grateful and the staff was very respectful too. A typical southern staff." During his third of four years in Alabama, Dr. IB was offered a permanent position at the hospital. The hospital board suggested that he take over a well-established practice and proposed that he "build a house for himself, and found a big piece of land for and said you should come be with us." Dr. B reluctantly refused the offer. Although, "he was making good money there and

[462] U.S. Congress, House, *Hearing before the Subcommittee on Ways and Means: Medicare's Geographic Cost Adjustors,* 107rd Cong., 2nd sess., 2002, 49-50.
[463] U.S. Congress, House, *Hearing before the Subcommittee on Ways and Means: Medicare's Geographic Cost Adjustors,* 107rd Cong., 2nd sess., 2002, 11.
[464] Dr. IB, interview with author, Illinois, August 3, 2015.

life was not that stressful and was able to play a lot of golf,"[465] Dr. IB was concerned for his children's educational prospects and feared distance from an ethnic cultural community. After completing the J-1 visa requirements to gain permanent resident status, Dr. IB relocated to a wealthy, suburban Midwest community and purchased a private practice from a white "pioneer" in the area. "To replace him and get in the good books of his patients was a challenge," he explained. He was the only "foreign doctor in the area."[466] This was different than the care work in Alabama. Dr. B explained, "Those patients were indigent people, they didn't have medical care. No matter what you do to them, they will still say thank you. Over here [suburban practice], you have to earn your thank you. They might ask you a hundred more questions before they say thank you to you. You have to work for that."[467] He was "able to keep 98% of the patients." His population was all white and "stayed with [him] because of his hard work."[468]

While the migratory trend to the suburbs was certainly a well-traversed route, there existed a contingent of physicians who chose to remain in rural communities establishing permanent lives in small towns across the country. The most famous example of this scenario was Abraham Verghese who chronicled his experience in *My Own Country*. Less famous but equally notable examples include Drs. B and NK who settled in small towns in Indiana and Illinois respectively building significant wealth as the primary cardiologist and radiologist for a considerable distances. Dr. NK explained his decision to remain in a rural area saying, "when you're in a small community, if you

[465] Dr. IB, interview with author, Illinois, August 3, 2015.
[466] Dr. IB, interview with author, Illinois, August 3, 2015.
[467] Dr. IB, interview with author, Illinois, August 3, 2015.
[468] Dr. IB, interview with author, Illinois, August 3, 2015.

work hard, you have the potential of generating more income because I was the only cardiologist there. There is no competition."[469] Dr. BK had a similar experience as the only radiologist in small town Indiana. For years, he expanded his practice, however, always working out of hospital lab space that was not his own. Dr. BK was enterprising and converted his professional monopoly into more of a complete business by opening up a network of lab analysis ventures strategically situated in small town Indiana. In 2002, a larger company purchased his business and he retired, settling in Chicago.[470] These physicians made their wealth and lives in rural towns marking them as different from the populations they served. Dr. BK explained that as his economic prospects grew, he felt it was necessary to become involved in all of the social community activities, so he "played golf, tennis, had barbeques, all of it." Similarly, Dr. NK played golf weekly at the community club and established a local scholarship to the community college, worked with the Salvation Army, started a soup kitchen in the area, and donated to hospital improvement project. He explained, "the people would come to me and say Dr. K, we need a check. They knew that I was the right person to help them do what they want to do."[471]

Often, IMGs extended their philanthropic sentiment back to countries of origin providing financial and institutional assistance for healthcare related needs. An Indian physician reported working with the government to set up Emergency and Ambulance services in Mumbai. Another Pakistani physician built a cancer clinic in Lahore. And a

[469] Dr. NK, interview with Eram Alam, Chicago, July 25, 2015.
[470] Dr. BK, interview with Eram Alam, Burr Ridge, Illinois, March 9, 2015.
[471] Dr. NK, interview with Eram Alam, Chicago, July 25, 2015.

third explained he regularly volunteered cardiology services in Pakistan and thought he might be "the first person to do a pacemaker over there."[472] The Asian Development Bank released a study documenting remittance practices in South Asia between 2000-2010. The report stated that remittances are the most important funding source for countries in South Asia. Over the ten-year course of the study, formal remittance flows increased from $16.13 billion to $72.51 billion.[473] IMGs repeatedly insisted on the importance of building something "back home" because they received an education through the government and people there, while proclaiming that their lives are "now here." The ties to home become foremost grounded in "sentiment…a central aspect of pluralist and multicultural imaginings of America in which immigrant groups are encouraged to preserve their culture, custom, and identity yet be fully embedded in an American mosaic."[474]Dr. NK provided an analysis of IMG motivations saying:

> We're doing these humanitarian, charitable, and educational programs things because there is a guilt. And you have to give back because we received a free medical education… There is a guilt there is no question about that. You can deal with the guilt by sending medical equipment, helping your medical school, helping with scholarships for students.[475]

For the physicians interviewed, guilt catalyzed and maintained remittance networks. This guilt, it seemed, emanated from a lack of significant financial debts, which expedited material successes in the United States thereby producing an indebtedness to the home country. IMGs felt themselves to have committed an extraction of sorts by choosing to

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[472] Dr. NK, interview with Eram Alam, Chicago, July 25, 2015.
[473] Mayumi Ozaki, "Worker Migration and Remittances in South Asia," *Asian Development Bank* 12(2012); 9-10.
[474] Nina Schiller, Nancy Basch, and Cristina Blanc, "From Immigrant to Transmigrant: Theorizing Transnational Migration," *Anthropological Quarterly,* 68(1995): 51.
[475] Dr. NK, interview with Eram Alam, Chicago, July 25, 2015.

remove their skilled labor from the conditions of its making. These IMGs' statements and actions highlight the affective dimensions of remittances. Drawing on the insights of Jenny Burman, the money and goods left behind or sent back to people in country of origin must be understood to exist within an affective register that includes responsibility, guilt and yearning. Burman's use of yearning rather than a "nostalgic longing for a lost object," is oriented towards a "looking around and ahead alongside the ever important act of looking back."[476] There is a futurity to the concept of yearning that is useful for understanding the IMG case. The remittance practices in the examples noted above are largely about redistributing remainders of their wealth, in amounts that prevent significant disruption to US status. Their affective longing is performed as obligation and mediated by sending medical equipment back to South Asia. The yearning they experience, I suggest, is oriented towards a removal of the feeling of indebtedness for often subsidized medical education. As G. C. Spivak writes on the disaporic condition: "Diaspora is full of affect… [a] connection with responsibility and reparation – we are here because we are guilty."[477]

Additionally, philanthropic giving and remittances can also be interpreted as a ritualistic practice or initiation into a certain class position. Scholars have documented this connection arguing that philanthropy is used as a practice to differentiate, stratify,

[476] Jenny Burman, "Remittance: Or Diasporic Economies of Yearning," *Small Axe* 12(2002): 50.
[477] G.C. Spivak, "Reading Stuart Hall in Pure Literary Terms," in *An Aesthetic Education in the Era Of* Globalization (Cambridge: Harvard University Press, 2012), 360-361.

and moralize using the frameworks of charity and goodwill.[478] IMGs, although embodying difference in other ways, were able to step into well-rehearsed class behaviors and norms by way of their professional status. Philanthropy, like the playing of golf repeatedly mentioned by IMGs, was a way to perform class, thereby securing a social position and creating a sense of fixity and belonging in the United States. With this social class transformation, there is a shift in the way IMGs are understood. No longer the inexperienced, snake charmers disseminating suspect care during their early years; they have become non-threating figures deserving of tolerance in the era of Homeland Security.

Dr. B's articulation of the relationship to his rural patients or Dr. A's "Hispanic" patient who inspired him to become a hematologist provide useful examples for fleshing out the statistical data regarding physician migration patterns. IMGs began their "American Dream" in urban and rural communities where medical choice was limited due to historically entrenched patterns of racial and residential segregation.[479] Into these immobile communities came hypermobile international physicians who learned to doctor on these bodies. IMGs were able to accumulate knowledge and training, and circulate with this expertise to maximize economic benefits. There was an extractive quality in the

[478] Rosenberg, Care of Strangers; Michael Katz, *In the Shadow of the Poorhouse: A Social History of Welfare in America* (New York: Basic Books, 1996); David Huseyn, *Progressive Inequality: Rich and Poor in New York, 1890-1920* (Cambridge: Harvard University Press, 2014.
[479] On residential segregation, see: Nancy Denton and Douglas Massey, *American Apartheid: Segregation and the Making of the Underclass* (Cambridge: Harvard University Press, 1993); Kenneth Jackson, *Crabgrass Frontier: The Suburbanization of the United States* (Oxford: Oxford University Press, 1987); Kevin Kruse, *White Flight: Atlanta and the Making of Modern Conservatism* (Princeton: Princeton University Press, 2007); Allan Spear, *The Making of a Negro Ghetto, 1890-1920* (Chicago: University of Chicago Press, 1967).

political economy of this type of knowledge production that resembled older colonial and neocolonial relationships. Michel Foucault writes about this in *The Birth of the Clinic* explaining the ascendency of scientific medicine would not have been possible without aggregated populations of the poor in hospitals. Through their bodies, the medical gaze was epistemologically reordered. Scholars such as David Arnold in *Colonizing the Body* and Laura Briggs in *Reproducing Empire* utilized these insights to historically analyze the relationship between knowledge of bodies and power in colonial India and colonial/neocolonial Puerto Rico, respectively. In drawing these parallels, I am in no way suggesting that IMGs provided substandard care or deliberately exploited inner city or rural patient populations. However, I am critiquing a systematic arrangement whereby foreign physicians, considered second-tier by organized medicine, were invited to provide care for marginalized populations in return for legal status. The time working in shortage area communities operated as a liminal period, a test and a temporal border that had to be endured in order to gain full legal citizenship. Their labor was the starting premise of their inclusion. If foreign physicians honored the terms of their immigration-for-service arrangement, they were granted permission to enter the citizenry of the United States. Once one cohort moved beyond the shortage area space into private, suburban practice, another cohort took their place ready to begin the process anew. And thus, the doctor shortage "crisis" in inner city and rural communities remained ongoing.

Representative Brand

Between 2000 and 2010, the "Asian" population in suburban areas surrounding the 52 largest cities grew by 66.2%.[480] In 2010, South Asians had the highest median income of Asian groups with average household earnings around $88,000 as compared to the average US (white) household of $49,800.[481,482] Overall, the census reported that Asians constituted 6% of the working age population, however, they made up approximately a quarter of the physician labor force, with South Asians in particular making up the largest percentages. [483,484] South Asian physicians were not the only elite professional contingent to enter the United States and enjoy these material successes. However, beginning in the 1990s, they were elevated into the mainstream American imagination becoming a recognizable brand apart from the rest of the South Asian category. To understand this privileged position, it is worth comparatively investigating the large contingents of South Asian moteliers, taxi drivers, IT workers, and engineers who remain largely unrepresented in this commodified space.

Pawan Dhingra's *Life Behind the Lobby* provides an in-depth look at Indian motel owners in the United States who own approximately 60% of the motel properties nationwide. His monograph begins with Al Gore addressing the 2002 convention of motel owners with laudatory remarks regarding their accomplishments – most notably

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[480] Joel Kotkin and Wendall Cox, "The Evolving Geography of Asian America," *Forbes*, March 18, 2015.
[481] http://www.pewresearch.org/fact-tank/2014/09/30/5-facts-about-indian-americans/
[482] The arrival of IT workers is an important contributing factor in this data.
[483] "Sex, Race, and Ethnic Diversity of U.S. Health Occupations," *National Center for Health Workforce Analysis,* January 2015, http://bhpr.hrsa.gov/healthworkforce/supplydemand/usworkforce/diversityushealthoccupations.pdf
[484] http://www.ama-assn.org/ama/pub/about-ama/our-people/member-groups-sections/international-medical-graduates/imgs-in-united-states/imgs-country-origin.page?

achieving the American dream. Dhingra shows how Indian motel owners neatly fit within the multicultural, liberal discourse of the contemporary nation-state. These foreigners, through their persistence, perseverance, and entrepreneurial nature seized openings in the market refusing to wait for assistance or instruction. They exemplified the possibilities of success in the United States. Valorizing their economic success above all else had the intended effect of effacing the historical and structural difficulties they experienced. However, irrespective of their economic success, ultimately, they were motel owners, proprietors of establishments associated with "prostitution, drug dealing, or other crimes" and/or places that cities "house otherwise homeless persons."[485] Dhingra demonstrates that the motel business was a family based operation with families often living on motel premises, disallowing any significant separation between work and leisure. Their unskilled, uncompensated labor propelled the success of motel establishments as family members performed all tasks on the premises. Dhingra spends one important chapter tracing the biographical genealogy of the motel owners, situating their history in the state of Gujarat, India. By explaining their migration within the frame of their long durée colonial and postcolonial history, he highlighted overlooked historical differences in the homogenizing, culturalist-oriented term South Asian, re-tethering amorphous notions of culture and "hard work" to histories of global capital.

[485] Pawan Dhingra, *Life Behind the Lobby: Indian American Motel Owners and the American Dream* (Stanford: Stamford University Press), 7.

The taxi driver, another prevalent iteration of the South Asian immigrant, comprises approximately 50 – 60% of the yellow taxi cab drivers in New York City.[486][487] According to the Taxi Licensing Commission Fact Book, this trend continues today with the greatest contingents of immigrant drivers originating from India, Pakistan, and Bangladesh.[488] In a project entitled *From the Ganges to the Hudson,* Johanna Lessinger comments on the story of these "less successful" migrants excised from the broader South Asian immigrant myth. Lessinger argued these unskilled[489] laborers are the unexceptional of the group. They experience "economic hardship, psychic pain, or the shock of adjusting to a new society," in a way that is often exacerbated by their immigration status. In *Unruly Immigrants,* Monisha Das Gupta narrates an interview conducted with a taxi driver. Das Gupta asked the taxi writer about his experience as a driver. The driver explained, "It's not even a guaranteed wage, forget about sub-minimum wage…[but] no one asks for your paperwork."[490] The taxi industry's exploitative labor practices and grueling demands in addition to the taxi drivers' questionable legal status meant they were unable to accumulate economic wealth or

[486] Monisha Das Gupta, *Unruly Immigrants: Rights, Activism, and Transnational South Asian Politics in the United States* (Durham: Duke University Press, 2006), 231.
[487] Biju Mathew, "The neoliberal firm and vested subsumption: Labour processes transformations in the NYC taxi industry," *Urban Studies* 52 (2015): 2051-2071.
[488] http://www.nyc.gov/html/tlc/downloads/pdf/2014_tlc_factbook.pdf
[489] Although considered unskilled in a US context, many completed advanced education in their countries of origin.
[490] Das Gupta, *Unruly Immigrants*, 104.

social capital. This reduced and stigmatized professional was given a diminished place in the realm of public imagination.[491]

The most proximate South Asian immigrant laborer to the physician in terms of perception of elite status is the IT worker. During the 1990s, using various immigration allowances, this community of skilled laborers was invited to the United States to fulfill labor shortages.[492] As Rafael Alarcon argues, immigrant labor has been identified as a key component in the growth of the sector and justified because "companies are competing in a global economy [and] need to have access to the best and brightest workers of the world."[493] South Asia, and particularly India, has become the largest contributor to this labor market, which rapidly increased in size in response to the increasing rate of technological production. To accommodate these changes, Xiang Biao in *"Body Shopping"* shows a new mediating business emerged, the body shop. Consultants and brokers around the world recruited Indian IT workers and connected them to clients as contracted, project-based labor. This system dictated the rhythms of supply and demand by "benching" workers, literally holding them in reserve by paying them small amounts of money to wait, to create a virtual labor shortage.[494] The body

[491] However, in contrast to their erasure from the elite South Asian progress narrative in the United States, the taxi driver regularly appears in the realm of mainstream cultural imagination. Using popular culture presence as a metric, this figure is omnipresent, either without speech or as momentary comedic relief. As such, they experience a reduction or a double muting within the South Asian diasporic community and the public sphere.

[492] Rafael Alarcon, "Recruitment processes among foreign-born engineers and scientists in Silicon Valley," *The American Behavioral Scientist* 42(1999): 1382.
[493] Rafael Alarcon, "Recruitment Practices," 1382.
[494] Sandro Mezzadra and Brett Neilson, *Border as Method, or, The Multiplication of Labor* (Durham: Duke University Press, 2013), 135.

shops utilized the competitiveness and speed of the IT world to their advantage. Biao writes:

> Whether or not there is a real gap between IT labor demand and supply is less important; what matters more is employers' desire for an ever enlarging labor supply to maintain the momentum in their expansion. Unlike a real shortage, a virtual shortage like this can never be balanced out…Thus, the coexistence of a skilled shortage and a significant level of professional unemployment can be a long-term feature of the New Economy, a feature epitomized by the routine practice of benching workers in body shops even as more are being hunted.[495]

I include the details of this labor arrangement to highlight the precarity of the IT worker in the current economic order. While they are categorized as educated and elite, an uncertain and possibly temporary/contracted status of their employment, their geographic sequestering to "high tech" communities and corporations, and the asocial and opaque nature of their work has contributed to less personal or intimate familiarity with this South Asian laborer.

During the initial physician migration post-1965, South Asian engineers and scientists also immigrated in significant numbers, often arriving as PhD students in the physical sciences, engineering, and biological sciences. Between 1960 and 1966, there were larger percentages of doctorates awarded to foreign students in these categories than US citizens, with Indian and Korean students represented in particularly high numbers.[496] For the years, 1964-1966, the data show that 51% intended to stay in the United States upon completion of their degrees. There was a "heavy involvement of U.S. universities as

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[495] Xiang Biao, *Global "Body Shopping": An Indian Labor Regime in the Information Technology Industry,* (Princeton: Princeton University Press, 2006), *17*.
[496] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 22.

employers" of these graduates.[497] This trend continued due to the 1990 Immigration and Nationality Act and "favored the immigration of engineers by almost tripling the number of visas granted on the basis of occupational skills from 54,000 to 140,000," further increasing the number of skilled Asians.[498] Between 1994-2006, "the ratio of foreign born scientists and engineers to native scientists and engineers doubled" in the United States.[499] A Duke University study published in 2007 reported that Indians have started more engineering and technology companies than any other immigrant group between 1995-2005.[500] Taken together, these data show skilled South Asian immigrants with considerable earnings potential and the ability to enter into a higher-class strata was not exclusive to physicians. Engineers and scientists of South Asian origin have a considerable presence within the market space and occupy prominent entrepreneurial and institutional positions. However, this significant market presence has not elevated their public presence suggesting an economic, or class position is not enough to bridge the social distance of the foreigner and project them into the public domain. A likely explanation for their absence, is due to their initial location in the siloed spaces of the university followed by occupations perceived as mechanical, detached and less universal less than medicine. The kind of labor they performed resulted in technical products

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[497] U.S. Congress, House, Committee on Government Operations, *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States: Hearing before he Committee on Government Operations,* 90th Cong., 2nd sess., 1968, 22

[498] AnnaLee Saxenian, "Silicon Valley's New Immigrant Entrepreneurs," *Public Policy Institute of California* 1999, 11, http://www.ppic.org/content/pubs/report/R_699ASR.pdf.

[499] Mariano Sana, "Immigrants and Natives in U.S. Science and Engineering Occupations, 1994 - 2006, *Demography* 47(2010): 801.

[500] Vivek Wadhwa, AnnaLee Saxenian, Ben Rissing, and G. Gereffi, "America's New Immigrant Entrepreneurs: Part I," *Duke Science, Technology & Innovation Paper* 23 (2007): Available at SSRN: http://ssrn.com/abstract=990152 or http://dx.doi.org/10.2139/ssrn.990152

related to computers or bridges and highways, objects generally understood in a more sterile, distant register outside of the domain of interpersonal interaction and intimacy.

A physician's professional jurisdiction, "birth, death, and pain" as Charles Rosenberg writes, encompasses a universality of experience allowing for a relatable professional, a necessary quality for a commodifiable brand. Therefore, class status is further refined through the type of labor performed. The South Asian physician is familiar to communities all across the United States occupying an intimate role based on social trust. These conditions produced a low-grade familiarity and a reluctant inclusion – a recognition that this figure must be tolerated due to their *particular* services rendered. Using Wendy Brown's insights regarding tolerance, at this low-grade level, what operates is a "personal ethic of tolerance, an ethic emerging from an individual commitment and has objects that are largely individualized."[501] This ethical stance structures the doctor-patient relationship, the ability to have trust in the intimate space of care. As Dr. AA stated above, "once the patient meets you as the doctor, they quickly accept you and it's all ok." The expedited acceptance and tolerance inhered in the doctor-patient situation is immediately in place to manage matters of "birth, pain, and death." The moral valence of care work places the recipient of care in a position where if they refuse to tolerate the caring doctor, it reflects negatively on *their* moral position. Brown writes, "Tolerance anoints the bearer with virtue" and "offers a robe of modest superiority in exchange for yielding." [502] Accordingly, in this doctor-patient interaction, the patient marshals tolerance for the foreign physician in hopes of alleviating their pain

[501] Brown, *Regulating Aversion,* 13.
[502] Brown, *Regulating Aversion,* 25.

and discomfort. Over time, the trust extended to the foreigner in the intimate context of the clinical interaction was projected onto the national cultural domain in the form of the medical expert. In the early 1990s, two of these experts, Deepak Chopra and Abraham Verghese, successfully made this transition to represent palatable representational forms of the South Asian physician: the ethnic fusion healer and the exceptionally innovative practitioner.

The Fusion Healer

In 1968, Deepak Chopra completed his medical training in India[503] and wanted to sit for the ECFMG exam. Unfortunately, the Indian government prohibited the exam for a brief period at this time and so Chopra had to travel to Sri Lanka for the test. Aziz Haniffa, the Sri Lankan newspaper editor, jokingly recalled, "I always tell Deepak [Chopra] that if it wasn't for Sri Lanka, you wouldn't be a millionaire." Soon after passing the exam, Chopra arrived to a community hospital in New Jersey ready to begin his residency training. He eventually became and endocrinologist establishing a private practice in New England.[504] In Chopra's bio posted on the website of his namesake Center, it lists the following institutional affiliations: "fellow of the American College of Physicians, a member of the American Association of Clinical Endocrinologists, professor at Kellogg School of Management at Northwestern University, Distinguished

[503] Deepak Chopra, *Return of the Rishi: A Doctor's Story of Spiritual Transformation and Ayurvedic Healing* (Mariner Books, 1991).
[504] Chopra, *Return of the Rishi*.

Executive Scholar at Columbia Business School."[505] Chopra's medical school was omitted. After this descriptive information, Huston Smith, prominent religious studies/philosophy scholar, is quoted as saying:

> Deepak Chopra has successfully blended ancient Vendata philosophy with his unique perspective on modern medicine to provide a vast audience with solutions that meet many needs of our modern age. He is among the influential scholars, authors and thinkers like Arthur Schopenhauer, Carl Jung, and Aldous Huxley who have found truth in the Perennial Philosophy and developed ways to help people apply that truth to their daily lives.[506]

In 1999, *Time* magazine identified him among the "Top 100 Icons and Heroes of the 21st Century" referring to Chopra as the "poet-prophet of alternative medicine."[507] Chopra's presentation of self mirrors the multicultural ideal. He is the quintessential hyphened person embracing professional sensibilities rooted in the fusion or the hybrid. By channeling secret knowledges of the East as a "poet-prophet", Chopra positioned himself as a conduit, a capillary through which this information is simplified, sanitized, and made palatable to the 100,000 people who purchased his book, *Ageless Body, Timeless Mind,* the same day he appeared on *The Oprah Winfrey Show*.[508,509] He transformed the magical, fantastical mysteries of the Orient into a commercial empire in the United States. The illusive secrets to happiness and well-being can now be conveniently mastered and

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[505] "About Deepak Chopra," The Chopra Center, http://www.chopra.com/about-us/deepak-chopra-md

[506] "About Deepak Chopra," The Chopra Center, http://www.chopra.com/about-us/deepak-chopra-md

[507] Hans Baer, "The Work of Andrew Weil and Deepak Chopra – Two Holistic Health/New Age Gurus: A Critique of the Holistic Health/New Age Movements," *Medical Anthropology Quarterly*, 17 (2003): 234.

[508] http://content.time.com/time/specials/packages/article/0,28804,1907409_1907413_1907555,00.html

[509] The Chopra Center, http://www.chopra.com/ccl/deepak-and-oprahs-shared-vision

uncovered. However, I suggest he needed his biomedical training in order to garner this mainstream success.

His early history and medical training in India and the United States, which were thoroughly biomedical, legitimated him as an authoritative figure on matters of sickness and health. Only after that validation, could Chopra reintegrate the cultural practices of India back into his healing lexicon and repertoire in a manner that was ahistorical and apolitical. The title of Chopra's book *Quantum Healing: Exploring the Frontiers of Mind/Body Healing* exemplifies this synthesis. By combining one of the most sophisticated concepts in physics with ancient wisdom from India, there is possibility for maximal health and wellness. He explained in the book, for proper healing and thinking, one must recognize and shift their field of energy. However, to complete this task successfully, one must identify their dosha, or mind-body type. Chopra's metaphysical politics and orientation firmly centered the power of the individual to alter their reality, denying a causal role to structural conditions.[510] The alignment with the liberal ethos of the individual able to will change made his products resonate with mainstream American cultural sensibilities. It secured him a spot as both a poet-prophet and a millionaire.

The insights of Stuart Hall and Edward Said remain presciently accurate in Chopra's commodified public identity. Hall writes in *Cultural Identity and Diaspora*: "the ways in which black people, black experiences, were positioned and subject-ed in the dominant regimes of representation were the effects of a critical exercise of cultural

[510] Baer, " The Work of Andrew Weil and Deepak Chopra,"240.

power and normalization…Every regime of representation is a regime of power…"[511] I extend these insights to the South Asian physician to suggest Chopra's use of historically available discourses regarding the magical healing powers of the East combined with his position as a physician undergirded his success in the United States. By fusing these two configurations of the Indian immigrant, one culturalist and one professional, he redirected Orientalist imaginaries for his material gain without disrupting common immigrant frameworks. Within this paradigm, Wendy Brown explains, "liberalism presumes to master culture by privatizing and individualizing it….Hence, culture must be contained by liberalism, forced into a position in which it makes no political claim and is established as optional for individuals."[512] The version of culture that Chopra adopted (especially in his early writings) is tolerated since this version of alterity can be normalized.[513] It can be incorporated and regulated in a mode that reduces its presence from threat to one of a tolerable Other.[514] Chopra is tolerated as a depoliticized healer who reinforces the power of the individual to change their circumstances, a basic tenet of liberalism.

The Exceptionally Gifted

Abraham Verghese's autobiographical text, *My Own Country: A Doctor's Story,* reflects his desired position vis-à-vis national belonging. Verghese was born in Ethiopia to a South Indian family and graduated from Madras Medical College in 1979. After

[511] Hall, "Cultural Identity and Diaspora," 225-266.
[512] Brown, *Regulating Aversion,* 21-22.
[513] Brown, *Regulating Aversion,* 26.
[514] Brown, *Regulating Aversion*, 27.

completing the requisite immigration procedures, he arrived to provide care in a small Tennessee town in 1980.[515] In the monograph, Verghese narrated his experience as an IMG through the AIDS crisis of the 1980s. Soon after his arrival, Verghese decided to deliberately opt out of an exclusively ethnic identity, instead making sure to travel easily between the "parochial world of Indians in America and the secular world of East Tennessee."[516] Early in the text, Verghese meticulously documented the "disturbing behaviors" of a fellow South Asian IMG who "hailed from a village outside of Karachi. [And] despite going to medical school in the city, he retained all of his country ways". Verghese enumerated his faults including, speaking "with a think guttural accent", "eating with his mouth open and with loud smacking sounds", "curt and chauvinistic" with the nurses, and indiscriminately urinating in the shared staff restroom.[517] Verghese continued to explain his desire to distance from this man saying, "I was not from his world, nor was I his keeper." The episode concludes with his reflection, "perhaps I consciously overachieved, worked hard to make up for [the Pakistani IMG], did everything to earn myself the appellation 'good ole boy'," a sign of acceptance and insider status in the Tennessee community.[518]

In Verghese's binaries, "parochial" versus "secular" and "foreignness" versus a "good ole boy", there is an indictment of the foreigner. In Verghese's statement, the foreigner is a supplement to the secular, the outsider who remains tethered to religion. In

[515] "Biography," Abraham Verghese Personal Site, http://abrahamverghese.com/home/biography/
[516] Abraham Verghese, *My Own Country: A Doctor's Story of a Town and Its People in the Age of AIDS* (New York: Simon and Schuster, 1994), 23.
[517] Verghese, *My Own Country,* 40-41.
[518] Verghese, *My Own Country* 41.

a properly formed liberal individual, this would not be the case since the non-secular would remain in the private sphere, depoliticized, and tolerated within the space of the interior.[519] Verghese's desire to assimilate was clearly stated in his unflattering characterizations of the other foreign physician and in his commentary following the description. To protect himself from the possibility of being associated with foreignness, and thus lesser quality, Verghese reflected on his motivations to overachieve and become "a good ole boy." He sublimated his foreignness by performing professional exceptionality. Verghese became a world-renowned AIDS expert, an identity that possibly allowed him to resist or at least deflect implications of foreignness.

Verghese rerouted his foreignness from himself onto his medical specialty, which at this time also carried with it a valence and mark of something unknown and outside. However, this transference was not always full or seamless. Commenting on his relationship with his socially ostracized patient population, Verghese wrote:

> I wondered after they left [my office] if there was an element of relief on their part to discover that the doctor they had come to see was a foreigner, an outsider…To come to a doctor's office, even a distant doctor's office, and tell their sexual secrets to a Caucasian face that could have just as well belonged to a preacher, a judge or some other archetypal authority figure in their town, might have been difficult.[520]

In his reflections, Verghese's ambivalent position as a foreign doctor is made apparent. Being marked as different in this particular circumstance, and perhaps *only* this circumstance, was professionally productive. His non-white, outsider status had the effect of lessening the authoritative distance inhered in the role of the doctor and the possible

[519] Brown, *Regulating Aversion*, 32-33.
[520] Verghese, *My Own Country* 96.

impact of social judgment. Verghese developed a camaraderie with his patients by virtue of their collective outsider status.

In another instance later in his career, Verghese's uncertainty regarding his position as an IMG and/or and AIDS doctor resurfaced. He narrated an experience with a local pharmacist who breached confidentiality to disclose the AIDS status of a patient to a dentist. Verghese confronted the pharmacist. The pharmacist responded by saying, "I don't want your business…I don't want your patients. I'll just take care of *my* doctors." Verghese explained his feelings after this interaction:

> The words 'foreign doctor' rang in my ears, even though he had not said them. My intuition was so strong that I could not write my discomfort off…Sometimes I felt that I was accepted only as long as they needed me, as long as I could be of service to them…. My conversation with the pharmacist and [my wife] seemed to exaggerate my feelings of alienation. And my alienation had so much to do with the fact that I was taking care of persons with AIDS."[521]

Verghese's discomfort as the words "foreign doctor" rang in his ears and his intuiting that his acceptance was premised on his medical service suggest that his attempts at masking his foreignness through professional life may not have been successful. Professional belonging and personal belonging were not fully commensurable and Americanness could not be attained through physician status alone. He was confronted with his double dislocation in the interaction narrated above, a position, which threw into question his status as a "good ole boy" and made him ponder whether the "clannishness of the Indian

[521] Verghese, *My Own Country* -249.

community" that he fought was not as parochial as he initially judged.[522] This anxiety quieted down as he gained prominence.

Abraham Verghese became a leading Infectious Disease expert, a prolific non-fiction writer, and a recent fiction writer who situated his last novel in migrations that resembled his own. The public exposure and engagement with his foreign status was possible after he mitigated his foreignness by becoming exceptional. The AIDS expert can be foreign because he is publicly seen foremost as an AIDS expert. He experienced inclusion by way of his institutional life. Verghese's innovative expertise was publicly understood as mastery over the threatening invader and in this capacity his own foreignness was allowed to assume a secondary position to the foreignness of AIDS.

Deepak Chopra and Abraham Verghese are representative cases. They are exemplar figures that highlight the nuances and texture of the South Asian physician brand. Although Chopra and Verghese negotiated their relationship to foreignness and physician status differently, both were able to translate their professional status into material success. Nearly twenty years ago, anthropologist Kamala Visweswaran wrote in an essay that class is a "contradictory and disjunctive site underlying Asian immigration and racial formation" in the United States and called for "more attention to how class determines the differential nature and experience of racial formation."[523] This call, emerging during the formative years of Asian American studies remains relevant, particularly with the heightened post-Terror, rhetorical climate. I attend to this

[522] Verghese, *My Own Country*, 248.
[523] Kamala Visweswaran, "Diaspora by Design: Flexible Citizenship and South Asians in U.S. Racial Formation," *Diaspora* 6(1997): 7.

observation to understand how the image of the South Asian physician became normalized in contemporary cultural production. There were other configurations of the South Asian immigrant possible given that multiple occupational subgroups existed in the United States. However, inclusion of these occupational groups, as indexed by their presence in the media, has been reserved. Taxi drivers and moteliers are unskilled laborers with a low class status -- they defy the "model minority." However, amongst those considered skilled workers, the doctor's prominent position is notable. While class is certainly an explanatory factor for their easy inclusion, it is an incomplete one. Class, in conjunction with the type of labor performed, was necessary to advance this cultural brand. As Lisa Lowe explains in *Immigrant Acts,* "It is through the terrain of natural culture that the individual subject is politically formed as the American citizen…it is in passing by way of this terrain of culture that the subject is immersed in the repertoire of American memories, events, narratives…"[524] The combination of care and class mitigated the threat of the foreigner. As a medical practitioner, the moral valence of care and healing is grafted onto the form of the foreign physician. In this specific configuration, the foreign physician is included and publically recognized.

Conclusion

The invisibility or elision of large occupational contingents of South Asian immigrants in contrast to the prominence of the physician indicates the class fissures in the South Asian diaspora often flattened to promote culture based "model minority" subjectivities. For nearly thirty years, a myriad of scholars from multiple disciplines have

[524] Lowe, *Immigrant Acts*, 2.

critiqued this collapsed category. I apply their critique to the figure of the South Asian physician disaggregating this professional to investigate the particularities of subject formation. The familiarity with this professional began in the intimate space of the clinical interaction, continued in the political realm as their class status increased, and was solidified in mainstream media. In matters of health, the South Asian physicians' position expanded from individual care provider to public medical expert in the last fifty years because of their legibility through market logics and the ethics of care.

In a 1987 article in *The New York Times,* Christopher Shea reported that the average Asian lives in a suburb that is 80% white and has an average annual income that is greater than the white residents in the same suburb.[525] The South Asian physician is extended measures of inclusion within a liberal democracy because they satisfy certain parameters such as "consumption capabilities, gender and kinship normativity, and bodily integrity," as explained by Jasbir Puar.[526] This version of the Other can be extended "measures of benevolence" and successfully incorporated into dominant discourses regarding American Exceptionalism through the inclusion into liberal markets, which operate as a proxy for the imagined State. Their professional identity allows them to participate in the "American Dream" by "acquiring middle to upper middle class status and moving into suburban communities, confirming the immigrant narrative, rather than disrupting it.

[525] Christopher Shea, "Asians Skipping the Inner-City," *The New York Times*, October 20, 1996.
[526] Puar, *Terrorist* Assemblages, xii.

During Surgeon General Vivek Murthy's confirmation hearing, Senator Pat Roberts enthusiastically welcomed him to Dodge City, Kansas explaining, "I'm going to invite you because we have a lovely doctor from India. She's in her mid-30s and she's highly respected by the community. And another doctor from India that did my carpal tunnel when I did a stupid thing. And so, I think you'd be right at home, and we would welcome you."[527] Although Murthy is a natural born citizen of the United States, Roberts' statement is a reminder of his forever- outside position in relation to a national imaginary. Both the immigrant generation and the hyphenated first generation are collapsed into one category, "forever foreign," as Mia Tuan reminds. However, Roberts makes clear that on account of his profession, he would welcome Murthy to Dodge City as he has welcomed two other Indian IMGs who provided him with needed medical services.

Roberts' welcoming notably occurred in a time when the War on Terror is ever-present. In *Terrifying Muslims,* Junaid Rana argues "the Muslim" is not simply a referent for Islam. It has come to "encompass many social and cultural practices, religious affiliations (from Muslim Sunni to Shia to Christian, Sikh, and Hindu) and social realities, that, through the process of state and popular racialization, is generalized." This generalized "Muslim" includes Arabs, South Asians, and other Muslims. Rana's analysis was confirmed by the 700 reported hate crimes against South Asian Americans, Arab Americans, and Muslim Americans in the three weeks after September 11th. There were

[527] Ashley Alman, "Senator Tells Surgeon General Nominee There are Indian Doctors Where He's From, Too," *Huffington* Post February, 5, 2015, http://www.huffingtonpost.com/entry/pat-roberts-vivek-murthy_n_4734238

four hate crime homicides, two were South Asian Americans, one Sikh and the other Muslim, during this time of Terror.[528]

After Terror events, the public's denunciations frequently referenced the physician as a way to plead for tolerance. For example, In March 2016, the Council on American-Islamic Relations executive director, Nihad Awad, stated in response to Donald Trump's anti-Muslim rhetoric: "He should apologize…to the Muslim doctors who provide healthcare to millions of Americans."[529] By structuring the reason for the apology in this way, Awad made the argument that Muslims are not terrorists *because* they are doctors. In this binary, Awad participated in the fixing and juxtaposition of these categories suggesting that inclusion should be premised on profession. Furthermore, doctors should be tolerated because they provide care. By performing this ethical labor, they are precluded from assuming the ethically devoid position of the terrorist. Care work softens the demarcations between us and them by virtue of its virtuousness. Being intolerant of someone whose objective is to alleviate suffering reflects negatively on those in the position to tolerate. Thus, as a feature of the modern West and against the intolerant Other, it is incumbent to extend this civility so as to embrace the higher moral position, a stance extended to South Asian physicians out of necessity when [one] does a "stupid thing."

[528] Maira, *Missing*, 11.
[529] https://www.cair.com/press-center/press-releases/13435-cair-muslim-leaders-to-demand-that-donald-trump-apologize-for-islam-hates-us-claim.html

CONCLUSION: THE CYCLE CONTINUES

This project ends where it began – in a state of terror with declarations of crisis. Fifty years ago, the doctor shortage crisis was pronounced with the expansion of Medicare and Medicaid during a time when totalitarian terror loomed. Presently, a doctor shortage crisis is intimated with the passage of the Affordable Care Act of 2010 during a time when the War on Terror pervades. In both of these moments, foreign physicians are largely excused from terror related discourse by virtue of their profession, or perhaps more explicitly by the virtues thought to be inherent in the profession. The Hart-Celler Act of 1965 inaugurated the conditional entry of FMGs from postcolonial Asian nations and the Affordable Care Act (ACA) will probably ensure that these conditions remain in place. In drawing parallels between these moments, Foucault's observations in regards to national health as a foundational component of national security are difficult to overlook.

During the Cold War, the United Stated modified its restrictive stance in regards to legal immigration from Africa, Asia, and Latin America. The modifications instituted a system of preferential, selective immigration for skilled labor, especially in markets where there was a shortage. The medical labor supply at the time was unable to meet the demands of the market. The imbalance disproportionately affected minority and low-income communities across the country designating them as health professional shortage areas. To stabilize the market and provide marginalized communities with healthcare providers, Congress invited Foreign Medical Graduates to provide care to communities largely neglected by US medical graduates. Physicians from around the world, and especially from Asia, responded to the invitation and served shortage area communities

ranging from rural Oklahoma to New York City. For foreign physicians, organized medicine, the government, and patients, the transition was not without its challenge.

Physicians entered a clinical environment wary of their presence. Patients distrusted the care of foreigners with unfamiliar accents and an appearance different than what was expected. Additionally, organized medicine distrusted medical knowledge from outside of the United States, assuming its inferiority and incompatibility with US medical standards and bodies. However, despite these reservations, foreign physicians became an essential component to the US medical system. In the mid 1980s, FMGs organized against discriminatory medical practices, which limited their personal and professional possibilities. Foreign physicians agitated for equal treatment with their US counterparts, leveraging the fact that they had become an essential part of the medical system. They fought for inclusion into a system designed to exploit them. As the awareness of their presence in the United States as a political and economic interest group was apparent, so too was their ability to enter into mainstream imagination as caring physicians. These physicians were embedded in the market and their presence was normalized. This initial wave of immigrant physicians eased the fears of America making way for the next cycle of foreign physicians during the next moment of crisis.

The ACA reactivated the healthcare manpower "crisis." As quoted in the *New England Journal of Medicine* in 2011, Representative Patrick Meehan wrote in a letter to other legislators that the United States is "on the cusp of a crisis in access to both

specialty and primary care physicians due to a growing physician workforce shortage."[530] In 2014, the Department of Health and Human Services designated 6,100 Health Professional Shortage Areas and estimating 16,000 more primary care physicians would need to be added to the current supply in these communities to eliminate the shortage. In 2015, the Association of American Medical Colleges projected a shortage of "between 46,100 and 90,400" physicians by 2025. The large range of the projection reflects the incomplete data on the workforce, an issue that was a problem in 1965 and continues to be an issue.[531] Once again, foreign physicians were suggested as a solution to the crisis. As David Skorton, a cardiologist and president of Cornell University explained, "As the nation ages and more previously uninsured individuals seek treatment under the Affordable Care Act, the health of millions of Americans may depend on the availability of more physicians and health workers form abroad."[532] Recycling an argument made fifty years ago, Skorton continued, "Through enlightened immigration policies, we can address our physician shortage and be a beacon for the rest of the world." His statement made clear that immigration could solve local doctor shortages as well as promote democratic ideals, an important objective during the War on Terror. And foreign physicians were identified as a pivot connecting these two issues.

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[530] John K. Iglehart, "The Uncertain Future of Medicare and Graduate Medical Education," *New England Journal of Medicine* 14(2011): 1341.

[531] Recognizing the need for this information, the Affordable Care Act included a provision to establish the National Center for Health Workforce Analysis to compile data in one central repository. However, irrespective of these discrepant figures, most stakeholders agree that more physicians are needed.

[532] Davik Skortin, "The Physician Shortage: A Place for Immigration Reform," *Huffington Post,*, 2/20/2013, http://www.huffingtonpost.com/david-j-skorton/doctors-immigration-reform_b_2727971.html

As a consequence of September 11th, the US experienced a shortage of tolerance towards those assumed to occupy the vague category of "Muslim" or "foreigner" generally decided based on ambiguous phenotypic characteristics.[533] The War on Terror labeled enemies with abandon, challenging the terms of inclusion for many who experienced refuge in their class or professional status. Anthropologist Sunaina Maira noted that South Asian American businessmen "were asked to get off planes, or undergo repeated searches at airports, or [their] bank accounts were investigated or closed down," and were forced to confront their precarious position within the multicultural nation.[534] The economic form of citizenship that permitted symbolic belonging was undermined during this "clash of civilizations" and the safety of the model minority subjectivity rescinded, "defigured and without stable referent."[535] However, I suggest that from within the unruly mass of Otherness, the South Asian physician was culled as an identity configuration that was worthy of tolerance and could be included based foremost on a professional identity. As mentioned in Chapter 5, post-9/11, this form was reproduced in fictional and non-fictional media representations alike. Sanjay Gupta, Atul Gawande, and Vivek Murthy mentioned earlier and fictional characters Mindy Lahiri (*Mindy Project*), Lawrence Kutner (*House*), and Neela Rasgotra (*ER*) to name a few, were given a significant presence and allowed to exist within the cultural terrain as speaking, expert characters, but only when professionally located as physicians.[536] This version of the non-

[533] Rana, *Terrifying Muslims*.
[534] Maira, *"Missing,"* 268.
[535] Achille Mbembe and Janet Roitman, "Figures of the Subject in Times of Crisis," 325.
[536] It could also be argued that Dr. Oz fits into this category, although I excluded him because of his Turkish descent. However, he is an interesting example of a Muslim identifying physician

white, elite immigrant was discursively fixed and reproduced in mainstream cultural imagination and allowed to become unthreatening and unremarkable during the War on Terror.

September 11, 2001 was popularly described in terms that signaled a rupture, a necessary discontinuity from September 10, 2001. It inaugurated the War on Terror, an affective regime premised on totalizing insecurity. However, as many scholars including G.C. Spivak, Jasbir Puar, and David Kanzanjian have argued, the effects of the event should be understood in terms of continuity rather than discontinuity. David Kanzanjian described the event as a flashpoint, "a bursting into action and being, not out of nothing but transformed from one form to another."[537] A flashpoint has the potential effect of blinding the past, "even as it spotlights the present and lights up the future."[538] In connecting the 1965 moment with the War on Terror through the figure of the foreign physician, the continuities are clear. As another cycle of physician shortage is proclaimed, the foreign physician is invited to provide care for communities largely neglected. They are used as a counterpoint against negative characterizations of immigrants and valorized for their care work – and so the cycle continues.

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who has risen to prominence in this era without significant resistance supporting my theory that the physician Other is an unusual case of exception in the United States.

[537] David Kanzanjian, *The Colonizing Trick: National Culture and Imperial Citizenship in Early America* (Minneapolis: University of Minnesota Press, 2003), 27.

[538] Puar, *Terrorist Assemblages*: *Homonationalism in Queer Times,* xviii.

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