

# Medical Migration to the U.S. The Case for a Brain Gain Theory<sup>1</sup>

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Sergio Moraes/Reuters

For almost 70 years now, brain drain theory has studied the migration of highly skilled professionals, especially from underdeveloped to developed countries, from the global South to the global North. In particular, the migration of medical doctors (MDs) and nurses has been seen as a most problematic and emblematic case for brain drain theory.

Countries such as Dominica, Grenada, or Ireland have a bigger proportion of MDs working abroad than in their countries of birth. Consequently, there are 0.5 physicians per 1 000 inhabitants in Dominica, while there are more than 3 physicians per 1 000 inhabitants in the main OECD countries that are destinations for medical migration. Life expectancy is also higher in developed countries: over 80 years in the U.S. compared to 57 years in South Africa, also a main country of origin for medical out-migration.

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However, studies estimate there will be a significant shortfall of 130 000 doctors by 2025.<sup>2</sup> International medical graduates are urgently needed to serve in critical access hospitals (those with fewer than 15 beds) and underserved rural areas.

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In general, rural communities in the U.S. find it more difficult to attract and retain physicians. As of 2014, almost 15 percent of the U.S. population (46 million people) was living in rural counties, but only 6.1 percent of physicians were practicing in those areas. A shortage of Spanish-speaking doctors and health-care-related translation also exists in both rural and urban areas.

Some critical perspectives show that health migration pits the interests of privileged groups in developed societies against those of less wealthy citizens of middle- and low-income countries.<sup>3</sup> They also point out that developed countries have a moral obligation to reduce the inflow of foreign health workers who have often been educated on public money, and therefore should return benefits to their societies of origin.

Health migration is a difficult topic that brings into conflict migrants' individual rights to freedom and well-being and vulnerable groups' rights to social justice in poor countries. Studying the phenomenon quantitatively may provide us with a pessimistic view, while qualitative data show that medical doctors are among the professionals who most circulate knowledge, form epistemic groups, and work for a health-related unofficial diplomacy multilaterally.

INDIVIDUAL PERSPECTIVES ON HEALTH MIGRATION  
OR THE OTHER SIDE OF THE STORY

Is medical migration good or bad for foreign MDs living in the U.S.? Do they regret having left their countries? In-depth interviews with 16 foreign physicians from the Houston, Texas health hub show a different side of the story. The individuals I interviewed came from China, Colombia, Lebanon, Mexico, Peru, and Romania, and they all agreed on their positive metamorphosis as scientists and practicing physicians in the U.S. Testimonies are shown below with anonymous quotes, in order to respect their privacy.

The first case is of Doctor A, a 50-year-old woman who has lived 20 years in the U.S., who studied medicine because

it was a major that took a long time and that would allow her to postpone marriage in a traditional society such as Lebanon, also torn by war when she was a child. She recalls,

I lived through the civil war between the ages of 10 until 26. And that's a big challenge because in the civil war you basically have your whole life on hold. When you don't even think of school, you don't think of [the] future, you don't think of what you want to do. . . . I kept going to school, but it was extremely challenging; there were many months of schooling that I lost. I'm not sure exactly what made me feel that I really wanted to go to school, but the simplest and silliest part of it is that I didn't want to get married because I knew that if I stayed home I would be an easy target or victim. I wanted to study medicine because I wanted something that would go for a long time, because a thing that ends somewhere means that I would have to struggle again with the marriage business.

And I do remember the first time I told my mother and my elder brothers that I wanted to go to high school. It surprised them; they asked me why I want to go to high school. Because if you're in the midst of civil war and poverty you cannot think ahead that school might get you to college, and college might get you to a better job. They cannot think that way.

So anyway, long story short, then, I wanted to go to college, and of course we didn't have the money [for me] to go to college so I went to the government college and I decided to do medicine and I finished my medical school in Lebanon. And I decided to go to the American University of Beirut because this is the time that I can switch without paying money. And I did. And I did internal medicine and oncology there, and then I decided that I wanted to come to the United States because, for me, getting the degree from Lebanon was not sufficient. It was not gratifying, because I felt that the system at the time was not strong enough to make me progress.

So I decided to come to MD Anderson in 1996 and I applied as a postdoctoral fellow. . . . One of the important physicians, also a foreigner, decided to help me. So I stayed here and I repeated everything that I did in Lebanon: my residency and my fellowship, and then I stayed on staff and that's how it worked.

She recalls she only practiced medicine in Lebanon for two years, and that was because she had to fulfill the requirement for the J1 Visa for academic exchange. She came back,

got married, became a U.S. citizen, and she is now a renowned scientist at one of the most important hospitals in the U.S., with major contributions to medical research and patient care in her field. She believes she was lucky to find people who helped her during her career and sees a difference of night and day between her life back in Lebanon and her present life in the U.S. She explains her professional success as a combination of people who believed in her and her own efforts. She thinks medical migration should be analyzed on a case-sensitive basis, depending on the combination of country of origin and destination. Dr. A says,

Lebanon is now very advanced when it comes to medicine. Almost everything that I do at MD Anderson I could do back in Lebanon, but not in Oklahoma or Mississippi. I trust sending my patients to Lebanon. So, do I feel that my country needs me? No. Because there's a surplus of doctors there, and every time I ask, they keep telling me they don't need me. Are there other examples where developing countries might need their doctors? Yes. The return of their physicians abroad may actually be of help for the local medical system. Do they reach the same level of MD Anderson? No. But they don't need to because this intermediate level is good for people.

I'm a radiation oncologist. I know that some African countries don't even have the machine to do my job. . . . Globalization has helped in bringing whoever is interested to the same level of knowledge. What is lacking in many of the countries is that they might not have the infrastructure or the money to practice what they've learned.

Dr. A's story clearly illustrates a couple of trends shown in studies with other MDs from different developing countries.

They are looking for better research opportunities and professional recognition abroad. The primary purpose of migration is therefore academic achievement, due to the fact that, back home, medical research is not or was not subsidized enough to allow a combination of medical practice and production of knowledge. Foreign medical doctors also feel satisfied about being able to take part in important research institutions in the U.S.

No matter what their conditions of out-migration, all the interviewed MDs are willing to give something back to their countries of origin, since many have benefited from public education there or just because they feel a certain affection for their country of birth. As they sometimes become experts

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recognized in the United States and even worldwide, they maintain professional networks with their colleagues in their countries of origin. This is an opportunity for future collaboration and a reason for ongoing cooperation between hospitals and universities in developing countries and U.S. health research institutions. Quoting from one of the testimonies,

I still have a lot of affection for and have roots in Mexico. However, I can develop more as a scientist being abroad. I am recognized internationally, so I can bring resources back to Mexico and watch out for Mexican interests. I think that from this point of view, I am a win for Mexico. (Dr. X, MD, graduate of the National Autonomous University of Mexico, 1999, currently with Memorial Hermann and McGovern Medical School, University of Texas)

This same sense of privilege at being at one of the best research and practice institutions in the world is stated by another Mexican MD who said,

It was very difficult to do research in hematology at the time I studied. This is one of the most important institutions for cancer research in the world. I have a lot more patients than I'd have in Mexico. I work with 10 of the most important authorities in leukemia in the world. I am in an ideal situation. Things turned out so well, that I sometimes wonder, "Am I not dreaming?" (Dr. Y, who received his medical degree from the National Autonomous University of Mexico in 1991, and currently practices and teaches at the University of Texas MD Anderson Cancer Center in Houston)

In general, foreign MDs in the U.S. must pass through a long, expensive certification process, which means either they have enough financial resources to pay the fees for the certification exams or they repeat studies they had already done at home, which requires a considerable investment of time. This limits medical migration of foreign physicians to a certain age group; most start their careers in the U.S. in

their late 20s or early 30s. However, if their migration is forced due to wars or violence in their countries of origin, they usually find employment in hospital administration, in the pharmaceutical industry, or even in areas completely outside the medical field.

## CONCLUSIONS

Highly valuable foreign talent definitely contributes to the advancement of research and economic development in the United States. They are always interested in sharing the knowledge acquired abroad; they participate in epistemic groups (international networks of health experts) and try to take part in academic events in their countries of origin.

Medical migration, then, is beneficial for the countries of origin that receive the experience acquired abroad; for the patients in the countries of destination, who receive good care based on the latest findings in medical research; and for the individuals themselves and their families, as they improve their quality of life. These doctors share their know-how

in the global health system, proving that international global networks of care may actually be more of a brain gain than a brain drain. ■■■

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## NOTES

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<sup>2</sup> Brian Palmer, "Bring on the Foreign Doctors. They're Just as Good as the Homegrown Variety. So Why Don't We Let Them Practice Here?" *Slate*, August 2015, [http://www.slate.com/articles/health\\_and\\_science/medical\\_examiner/2013/08/doctor\\_shortage\\_foreign\\_doctors\\_are\\_just\\_as\\_good\\_as\\_the\\_homegrown\\_variety.html](http://www.slate.com/articles/health_and_science/medical_examiner/2013/08/doctor_shortage_foreign_doctors_are_just_as_good_as_the_homegrown_variety.html).

<sup>3</sup> James Dwyer, "What's Wrong with the Global Migration of Health Care Professionals?" *Hastings Center Report* vol. 37, no. 5, 2007, pp. 36-43; and Carywn R. Hooper, "Adding Insult to Injury: The Healthcare Brain Drain," *Journal of Medical Ethics* vol. 34, no. 9, 2008, pp. 684-687.