Cold War Crises: Foreign Medical Graduates Enter the US Workforce

[This is the second chapter of a book manuscript entitled *The Care of Foreigners: A History of South Asian Physicians in the United States, 1965-2016*. The first chapter explores the historical circumstances that linked physician manpower and immigration policy in the United States. I argue for the need to deprovincialize the problem of US doctor shortage and show how liberal economic policies and ideological shifts to multiculturalism influenced the intimate spaces of healthcare delivery in the United States. This paper shifts scale from the geopolitical and economic to the documentary mechanisms implemented to account for the influx of postcolonial medical labor in the United States.]

On November 11, 1976, Tahir Akbar was eager to be first in line at the US Consulate in Lahore, Pakistan. In a 2016 interview, he recalled arriving at the office a few minutes before it opened waiting anxiously with documents in hand, checking and rechecking his paperwork to ensure all was in order.[1] Upon entering the interviewing agent's office, Akbar handed over his file. The folder contained his freshly minted diploma from King Edward Medical College, transcripts, and a certificate stating he successfully passed the Educational Commission for Foreign Medical Graduates exam—"the ticket to America" as it was commonly called.[2] After passing the visa interview, which consisted of one question, Akbar was granted legal status on the basis of his medical credentials. On December 4, 1976, less than a month later, he landed in New York at John F. Kennedy International Airport ready to work as a Foreign Medical Graduate (FMG).[3] Akbar intended to follow his classmates and join the burgeoning workforce of postcolonial physicians providing care to America's marginalized communities—places US physicians were unwilling to go. However, to enter clinical practice, Tahir Akbar had to assemble a dossier of documents, an archive of expertise necessary to make him legible to US publics and US patients. This paper traces the journey of a FMG from country of origin to work placement in the United States, paying attention to the bureaucratic structures and documentary disclosures necessary for this migration.

By the time Dr. Akbar arrived in the United States, this migratory route was well documented (Stevens et al., 1978). Initiated by the passage of the Hart-Celler Immigration and Nationality Act of 1965, approximately 75,000 FMGs entered the US healthcare system to staff hospitals in poor, urban, and rural communities in only the first decade of the bill. Two crises converged to inaugurate this transnational migration: a domestic skilled labor shortage and the geopolitical threat of communism. In response, US lawmakers promoted immigration of foreign physicians from Third World Asian countries as a strategic policy mechanism to encourage democratic ideals and connectivity with the United States while simultaneously bolstering physician supply (Alam, forthcoming). Taken together, these crises produced an arrangement whereby local hospital staffing became tethered to foreign policy objectives.

The transnational migration of Asian physicians bore the markers of its Cold War conception. The political demands that the Unites States act as the harbinger of democracy forced the dismantling of the previous 1924 immigration bill, which included a quota system and barred Asian immigration, on grounds that it was closed and isolationist (Lowe, 1996; Ngai, 2014; Zolberg, 2008). However, the openness and inclusion lawmakers understood to be a necessary part of the Hart-Celler Act of 1965 barely concealed paranoid suspicions and fears of difference. Additionally, the First World's economic demand for unrestricted global free markets was strategically manipulated by legislative actions designed to direct scientific and medical labor to the United States. This was not only to supplement US health manpower, but also to shore up significant numbers of medical and techno-scientific laborers to guarantee competitiveness with the Soviet Union (Forman, 1987; Kevles, 1990). The entanglement of these demands meant that the political and legal identities of foreign physicians were primarily understood through processes that emphasized a professional identity. Therefore, to

be made into legal US residents, it was simultaneously necessary to be made into US sanctioned doctors.

Documents became the primary route for this type of identification and disclosure. Within the document, the foreigner was made knowable and recognizable, thus reducing their threat. State and local bureaucracies were tasked with managing this process. They oversaw, verified, and validated a Foreign Medical Graduate'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 (Das and Poole, 2004; Gupta, 2012; Hull, 2012; Weber, [1922] 1978). It is in the routinized and banal bureaucratic mechanisms of forms, applications, and files that boundaries are defined, permissions granted, and people transformed. Although these systems seem innocuous and objective, they are important sites where cultural norms are created and inculcated and social inequalities produced and reproduced (Das and Poole, 2004: 13). The importance of bureaucracy and the document to govern difference has been researched most thoroughly in relation to colonial governmentality and the archive (Foucault, 1969, 1970; Hacking, 1982; McKay, 2012; Roy, 2016; Scott, 1998). Ann Stoler (2010) writes that 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" (Stoler, 2010: 1). The document and the archive stabilized populations, classifying people using rationality and organizational method. It was a technique to soothe anxieties of colonial governments and

overlook their lack of knowledge about colonized peoples (Bear, 2013; Bear and Mathur, 2015; Silverblatt, 2004).

This legacy of colonial governmentality has persisted into the present through the continuity of bureaucratic inscriptional practices and logics (Hull, 2012; Povinelli, 2002, Weld, 2014). These governance strategies were amplified during the Cold War as "information" and "transparency" captured the political imagination of those in power. Kregg Hetherington (2011) explains, "The failure of democracy and of markets in the Third World were both attributed to a lack of transparent information available to the citizenry" (p.4). In this new orientation, the document is central. Hetherington's project describes 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 was less to hide. The opaqueness of documents or the archive is what could lead to political upheaval or at worst a totalitarian regime (Hetherington, 2011). As thousands and thousands of FMGs arrived from Third World countries to provide medical care, bureaucratic mechanisms were used to fix these mobile individuals and make them transparent to the nation. It was a political technology used to uncover false identities, expose potential deficiencies, and monitor possible threats.

For foreign physicians, the paper life became a foundational mode of political recognition. 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. The article 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. Although documents could verify a person, they also had the potential to falsify a FMG. The final section investigates the relationship between claims of FMG fraud and documentary authenticity.

Phrases such as "un*documente*d immigrant" and "having *papers*" highlight the discursive linkage between documentation, immigration and governance. Recent scholarship explores the catastrophic conditions endured by those without papers – the immigrants considered explicitly exterior to the nation. This work often centers the territorial border and focuses on the violence, precarity, and extreme dislocation caused by the geographic demarcations (Das Gupta, 2006; Fassin, 2011; Golash-Boza, 2012, 2017; Hondagneu-Sotelo, 2008; Ticktin, 2011). While the political stakes of the geographic border are undeniable, this article shows how routine governance practices work in tandem with territorial policing to differentiate between individuals and create hierarchies of belonging. For foreign physicians invited into the nation, the bureaucratic border was the foundational site that marked their difference and determined their fates. By focusing on the process of documentation rather than solely on the objects produced, I uncover the work and translations FMGs performed to make themselves legible to and compatible with bureaucratic systems. Ironically, through this process aimed at inclusion in the US medical force, foreign physicians' differences were amplified and concretized. They were affixed with the classificatory label, *Foreign* Medical Graduate, orienting them towards the outside. In this way, the documents produced and consolidated the foreigner. By analyzing the experiences of documented immigrants in the

United States, the parameters and limits of liberal inclusion within the category of immigrant become apparent.

Motivations for Migration – Push and Pull

King Edward Medical University in Lahore, Pakistan is the oldest and most prestigious medical institution in Pakistan. In a 2016 interview, Drs. TA and KB, both graduates of King Edward, explained that students studied for the entrance exam from the age of thirteen because competition was notoriously fierce. However, upon completion of their medical degrees, few graduates remained in the country. Dr. TA recalled, "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, to England or the United States." Dr. BK, a graduate of the only medical college in Damascus, Syria, left for his postgraduate training. In 2015, 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." These doctors recall a momentum, a forgone expectation around their departure from their country of origin. When asked about his expectations regarding America, Dr. BK answered, "The United States was the buzz word, the future, better medicine." 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. HM, a physician trained in Hyderabad, India, shared a story of a young boy in need of a blood transfusion due to complications from a ruptured spleen. In a 2015 interview,

he narrated the difficulties associated with this case, which ultimately influenced his decision to leave India.

> 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 qul'li [porter], 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.

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 in a 2014 interview. 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. Dr. NS's migration to the United States was prompted by this frustration and an awareness of a possibility for better patient care elsewhere.

Additionally, the political situation in the 1960s and 1970s in South Asia significantly intensified the desire to emigrate. Pakistani doctors frequently mentioned avoiding 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. Other physicians chose to migrate to nearby countries in the short term to avoid military service. Dr. NK explained in a 2015 interview that he 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." 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 (Wright, 2016). Cycles of war produced perpetual global shortages.

When justifying the migration of skilled professionals to the United States, Dr. Charles Kidd, the Executive Secretary for the Federal Council on Science and Technology, testified before Congress and explained that professionals would be more inclined to stay in sending countries if there was "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" (US Congressional Hearing on Brain Drain, 1968: 55). 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" (US Congressional Hearing on Brain Drain, 1968: 57). 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 (Escobar, 2013; Ferguson, 1994; Scott 1999; Steil, 2013). In this way, migration policy operated as a reconstituted form of colonial governmentality and value extraction (Foucault, 2003).

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 up (US Congressional Hearing on Brain Drain: 63)? In other words, what are the steps required to create and maintain a transposable, commensurate supply of global medical labor? And could these laborers 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 standards and oversight procedures in the 1960s and 1970s. Inconsistencies over state versus federal jurisdiction, changing visa requirements, and additional competency examinations were a few examples of the unpredictable terrain foreign physicians navigated to become recognized medical professionals in the United States.

After much discussion and many failed attempts, the American Medical Association, American Academy of Medical Colleges, and the US government established the Educational Commission on Foreign Medical Graduates (ECFMG) to manage the uncertainty of a global medical manpower. Although a version of this organization originated in 1956 in response to physician migration from post WWII Europe, it was repurposed as the institutional guide for foreign physicians from the Third World in the 1960s (Hallock, 2006). 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 (p. 57-58).

The ECFMG had the unenviable task of deciding what criteria to use to "recognize foreign medical schools", defining what constituted "qualified," and identifying foreign medical graduates thoroughly. Their mission was to make foreign physicians legible to the American healthcare system through bureaucratic procedure. ECFMG had to assemble a protocol to manage the transnational migration of global medical labor to the United States.[4] They had to do what Mary Douglas (1968) calls "entropy reducing work" by stabilizing social classifications (p.48). The organization became an obligatory institutional passage point for FMGs throughout their careers.

The first step in the 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 India, Dr. HM relied on generous subsidizes from his family while he committed a year to preparing for the exam. In a 2015 interview, he recalled his frustrations:

> 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.

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 (1992) 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" (p. 65-66). FMGs' local, provincial medical knowledge was reformatted into a transcendent, universal standard through an exam. This process exemplified what Sheila Jasanoff (2006) calls creating "empires of legibility," where "communal standards are imposed through administrative simplification, normalization, and erasure" (p.277). 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 possible and coordinated.It had the capacity to "transform, translate, distort, and modify the meaning or the elements [it carried]" (Latour, 2005: 39). 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.

The ECFMG certificate was the first necessary document in the case for immigration; the next was obtaining 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. There were multiple, inconsistent and overlapping routes for entry. The most common status was the J-1, a visa instituted during the Cold War as a diplomatic tool to foster educational exchange between the United States and other countries. J-1 visas were designed for visitors who would return to their home countries after completing their educational exchange. The return requirement was initially relaxed for FMGs and they easily converted their J-1 visa to permanent resident status after residency training (Agarwal and Winkler, 1984; Steven et al., 1978: 62-63). 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" (US Congressional Hearing on Foreign Medical Graduates, 1977: 3).

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 (AAMC Position Statement, 1974). 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 Marin County, before a Congressional Committee in 1974 (US Congressional Hearing on Health Manpower, 1974: 731). However, the number of FMGs admitted to the federal system was far fewer than those granted J-1 visas.

While waiting for the visa application to clear in their country of origin, most 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, a 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 (Splisbury and Cooney, 1998). 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 John F. Kennedy International Airport and took a taxi straight to the hospital. Dr. KB was given a room and told to report to duty in the emergency room the following day. 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" (Us Congressional Hearing on Health Manpower, 1974: 399). 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. Some suggested that the ECFMG was simply a basic science and 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 before Congress:

> 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 the U.S. health care system has resulted in a double standard for the minimal control of physician manpower (p. 635-636).

The idea for the state licensure exam was that it would assess and measure "fitness for practice," not simply 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 (Johnson and Chaudhry, 2012). 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 (Johnson and Chaudhry, 2012: 59). 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" (Johnson and Chaudhry, 2012: 123).

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 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" (US Congressional Hearing on Health Manpower, 1974: 778). 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" (US Congressional Hearing on Health Manpower, 1974: 778). FMGs struggled with this exam for similar reasons to the ECFMG exam. However, many states kept requirements low to ensure enough foreign physicians made it through to fill vacancies in undesirable medical institutions (US Congressional Hearing on Health Manpower, 1974: 747).

For foreign physicians, the path to licensure was still incomplete after the additional FLEX exam. Dr. Robert Derbyshire, a longtime member of the Federation of State Medical Boards, commented during a 1974 Congressional hearing: "[FMGs] run into a series of extra requirements when he wants a license, or when he wants to move from one State to another…These people [FMGs] are completely bewildered by this" (p. 774). In the years to come, FMGs waged a political battle against organized medicine and the government urging them to remedy problems with medical licensure. In a 2015 interview, Naveed 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. 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 irrelevant as a professor writing about when I was a student [over ten years ago]." 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 for 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 knowledge and English language proficiency were the first steps in the process. However, an exam was insufficient for assessing clinical skill and bedside manner. To reduce anxiety, further 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. Producing this archive of documents and cases was an exercise aimed at combatting uncertainty and doubt. It was a "condensed site of epistemological and political anxiety," (Stoler, 2010: 19) intended to eliminate the possibility of fraud or prevent the rise of a seedy medical underground outside of the medical establishment's purview.

Documents, Duplicity, and Doubt

Bureaucratic procedures were supposedly imbued with detached objectivity and conveniently obfuscated the social mechanisms embedded within. Compiling documents in a particular way and the technicality of forms – these practices played a significant role in determining professional possibilities for a foreign physician, even after they assembled their archive of expertise. 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.[5]

Dr. T completed his training at Bangalore Medical College in 1975. In 1988, after working in the United States for over eight 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.[6] 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![7]

Dr. T received a short and terse reply to his over two page explanatory letter. The Director basically stated: "I can't interview you or submit your application."[8]

The first issue with the application, the way Dr. T's name was written, raised questions because 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. Michel Foucault (1979) theorized the modern form as text and argued that the physical organization of the form, the construction of spaces and boxes, denotes a proper way of identifying oneself. It is in these seemingly insignificant bureaucratic normalizations and demands that power is exerted. The cultural norms and practices that sufficiently identified and structured Dr. T's existence in country of origin were incommensurate with the spaces on US bureaucratic forms. And neither additional cultural explanations, nor "objective" newspaper article were sufficient enough to overcome bureaucratic determinism. They were unable to mediate and translate Dr. T between schemes of classification utilized in India and in the United States. In the end, unless he produced himself within allotted formulaic spaces, Dr. T was considered suspicious and unverifiable in the United States. His identity was incompatible with the process of identification.

The second problem with the application was the method of document delivery. 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. And mitigating factors including the "real practice difficulties in obtaining letters" from medical schools from "far off lands", or the fact that Dr. T was working in the United States for many years were unpersuasive. In response, the Director wrote, "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." The Director's remarks on the failure of the Indian medical school to follow his conceptions of standard operating procedure could be understood as in indictment of a less developed bureaucratic ethos or an assessment of the medical school's quality more generally. This episode highlights the connection created through documents, between the moments of document making and the moments of evaluating. In this evaluative capacity and role, the application and proper documentation must adhere to procedural standards and any data or circumstance outside of this frame is rendered either insignificant or invisible.

Dr. T supplied additional letters of support from US trained peers to bolster his application. It was a compensatory strategy for his hand delivered medical transcripts and foreign naming practices. Dr. T's reference to the nationality of the letter writers suggested an internalization of his subject position within the American medical establishment and recognition of his second-tier status. 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 (Fanon, 2008; Taylor, 1992). Historically, colonial and postcolonial institutions of governance relied heavily on documents in lieu of people as material objects with the capacity to vouch for a person or an action (Hull, 2012: 8). In the case of Dr. T, the letters of support authored by *US peers* were 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" (Woolgar and Nyeland, 2014: 56) and a "hierarchy of credibility" (Stoler, 2010: 23) that elevated the reference writers' testimony over Dr. T's original documents.

Ultimately, the case had an unfavorable outcome. The Director wrote in his final reply: "I have been ordered to discriminate against incomplete applications." In this response, the Director distanced himself from the decision by blaming procedural order and discrimination against an "incomplete application." The Director located agency outside of his jurisdictional authority and placed it within an amorphous, bureaucratic system with strict rules for a proper application (Gupta, 2012: 148). By divorcing himself in this way, he infused the document 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 (Heimer, 2006: 108). The case based analysis allowed for a masking of the sociality of the document, while a biographical analysis may include Dr. T's past performance and positive references, instead of simply his "incomplete application." Max Weber refers to this as the bureaucratic demand for the calculability of rules. "Bureaucracy develops the more perfectly…the more completely it succeeds in eliminating from official business, love, hatred, and all purely personal, irrational, and emotional elements which escape calculation" (Weber, [1922] 1978: 975).

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 (2012) describes as a "graphic regime of surveillance" (p.10). 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" (Hull, 2012: 26). 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.

Fraudulent Foreigners?

During the twentieth century, organized medicine in the United States consolidated power and authority by actively targeting and removing "frauds" from the ranks of the profession. Over the years, this antagonistic label was used against women, alternative healers, and non-white professionals, and continued with foreign physicians.[9] 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* (1954): "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 schools." 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 before Congress:

> 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 (p.50).

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 (Butter and Schaffner, 1971; Stevens et al., 1978) Despite their instrumental role in medical care, organized medicine maintained a fraught relationship with foreign physicians – at times alleging claims of fraud. In these instances, the document operated as a gatekeeper and was an important object used to arbitrate truth claims. It became a formal structure that was "easily recognized" and endowed with "self-validating truth" (Douglas, 1986: 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. Even as he rests barely conscious in an Anchorage hospital room…the medical odyssey of Kandaswamy Balasubramaniyam remains mysterious…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.… Acting on an indictment from [Illinois], Alaska officials cornered him in an Anchorage rooming house Saturday… 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, is illustrative of the fear and sense of risk that organized medicine felt in regards to this unknown labor pool.

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 the appropriate 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 World Health Organization's list of "approved medical schools" used by the ECFMG to validate credentials (Jones, 2016) or his answer to questions about the number of books in his medical school library on state licensing questionnaire may not have been sufficient. 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 (2010) identified in competing regimes of truth: the documents versus the insistence of the person. In this case, the documents judged Dr. B as a fraud since the paper artifacts were endowed with "self-validating truth" (Douglas, 1986: 48).

Fear of an undocumented, underground network of medical practitioners further amplified distrust and suspicion of FMGs in general. Through various visa configurations and immigration routes, some physicians managed to enter the United States without the sponsorship of the ECFMG or an ECFMG exam certificate. The exact numbers are uncertain and probably small, but the existence of unlicensed, unaccounted for doctors fed into the

rhetoric of a rapidly expanding "medical underground" (Stevens et al., 1978). These mostly Asian, unlicensed individuals were called "doctor" because they held medical degrees from abroad, explained journalist Lawrence Altman in 1974. He wrote in *The New York Times*, "But the patient might not know that the doctor was unlicensed" and probably practicing without supervision. Some "do surgery in operating rooms or in the emergency wards. Others give anesthesia. Many practice psychiatry."

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" (1974) investigated the involvement of these physicians in the daily functioning of hospital life and patient care. The study authors revealed the following:

> [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.

Some unlicensed FMGs reported performing minor surgery and a few completed major operations (Weiss et. al; 1974: 1411). Hospital administrators employed the "medical underground" as a cost effective strategy during a time when hospital operating costs were rising and budgets declining. Dr. Robert Weiss, the first author of the study, was invited to testify on the issue before Congress in 1974. He explained that the "medical underground" received lower compensation because these physicians "cannot demand the same wage that they would get if fully qualified" (p. 640). In 1974, on average, these doctors received under $10,000 a year in salary (Weiss et al., 1974: 1457).

Tahir Akbar, the physician introduced at the beginning of this article, earned much less than this when he arrived for work at New York University's main hospital. He arrived in Manhattan with five hundred dollars, the maximum amount of cash one could carry overseas, and began calling hospitals in search of employment. Dr. Akbar had yet to assemble the appropriate documents and licenses for medical practice. In a 2016 interview, he recalled his first employment experience in the United States:

> [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].'

Dr. Akbar was eventually given a raise and continued working in this capacity for another five months. As long as he completed required tasks, this prestigious medical center was willing to keep him on staff, irrespective of his documentary status.

Akbar's case illustrates how FMGs were interpreted and treated through readily available tropes of foreignness and cheap labor. Hospital administrators manipulated both the immigration and medical systems in order to maintain their staff. Because immigration sponsorship paperwork was initially submitted through hospitals, FMGs were abused and beholden to these institutions. Some programs placed foreign physicians in non-approved, unofficial residency programs to satisfy their hospital staffing needs. Other hospitals created special fellowship training programs to prolong the stay of the FMG for a year or two beyond the time required to complete their residencies (US Congressional Hearing on Foreign Medical Graduates, 1977: 4). US Representative Joshua Eilberg who presided over the 1977

Congressional hearing on Foreign Medical Graduates asked, "Did not the hospitals in many, many cases take advantage of FMGs and use them as virtually indentured labor" (p.44)? The question remained unanswered, but the point was made – hospitals were manipulating immigration mechanisms in order to secure staff. A better system with protections for immigrant physicians was necessary. In the 1980s and 1990s, foreign physicians collectively organized to demand the bureaucratic process they were subjected to be streamlined. They felt taken advantage of by the medical system, treated like "second rate doctors...working in some small hospital, some ghetto place, or asylum," Naveed Shah explained.He continued, "A number of FMG's have suffered a lot of injustice, tremendous economical loss and mental anguish in the areas of jobs, promotions, hospital privileges, licensing, and reciprocity,"due to unpredictable documentary demands (US Congressional Hearing on Health Manpower, 1988: 408).

Conclusion

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. These apparently stable bureaucratic products were "devices for handling objects characterized by motion," (Appadurai, 2001: 5) symbolic artifacts that connoted institutional acceptance in the Unites States. Within the document, the foreigner was 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, since 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. 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. Documents made the foreign physician transparent to US publics in a way that was not necessary for their US counterparts whose inclusion was unquestioned.

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 proficiency in the other. Proper documentation produced some standard to judge biomedical fact knowledge, but clinical skill was difficult to police. The American Medical Association 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. Most hospitals were primarily concerned with the "services" the FMG rendered rather than providing training opportunities (US Congressional Hearing on Foreign Medical Graduates, 1977: 4). Hospital

administrators even went so far as to circumvent national medical standards in order to attract and maintain their foreign staff. 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 (Butter and Schaffner, 1971: 136-137). They were willing to provide care in inner city and rural communities often overlooked by the US trained workforce.

Notes

1. I conducted all oral history interviews presented in this paper between 2014-2016. These were long form autobiographical open-ended histories of Foreign Medical Graduates who arrived in the United States during the first large-scale migration between 1965-1977.
2. The Educational Commission for Foreign Medical Graduates was a regulatory body in the United States. It will be explained later in the article.
3. I use "foreign," "foreigner," or "Foreign Medical Graduate" to refer to the first wave of immigrants who came largely from Asia. This was the term used by my interlocutors and found in the literature of the time. In the early 1990s, as part of a political campaign, FMG leaders decided to change their classificatory label to International Medical Graduates (IMG). Neither they, nor organized medicine used this phrase with any regularity until the late 1990s. Additionally, I use "foreign" to differentiate between "foreign" born FMGs and US born FMGs who went abroad for medical school.
4. See also: Bowker and Starr (1999), Fleck, ([1935]1981) Hacking (1990), and Jasanoff (2006).
5. These letters belong to a personal archive of a FMG organizer who collected cases of discrimination to present to the American Medical Association and Congress in the 1980s and 1990s. The archive is located in Potomac, Maryland.
6. Medical Director to Dr. T, 17 November 1988, in Navin Shah personal archive, Potomac, MD.
7. Dr. T to Medical Director, 22 November 1988, in Navin Shah personal archive, Potomac, MD.
8. Medical Director to Dr. T, 8 December 1988, in Navin Shah personal archive, Potomac, MD.
9. On frauds and alternative healers, see: Bivins (2010), Frohok (1992), Johnston (2004), Porter (2003), Robins (2005), Whorton (2004), and Young (1967).

References

AAMC Position Paper (1974) Graduates of Foreign Medical Schools in the United States: A Challenge to Medical Education. *Journal of Medical Education* 49: 830.

Agarwal V and Winkler D (1984) Migration of Professional Manpower to the United States. *Southern Economic Journal* 50(3): 813-840.

Alam E (forthcoming) Cold War Crises: Foreign Medical Graduates Respond to US Doctor Shortages, 1965-1975. *Social History of Medicine*.

Altman L (1974) Many foreign physicians in US found unlicensed. *The New York Times*, 20 June.

Appadurai A (2001) Grassroots Globalization and the Research Imagination. In: Appadurai A (ed) *Globalization*. Durham: Duke University, pp. 1-21.

Balibar E (2002) *Politics and the Other Scene*. New York: Verso.

Bear L (2013) The Antinomies of Audit: Opacity, Instability and Charisma in the Economic Governance of a Hooghly Shipyard. *Economy and Society* 42: 375-397.

Bear L and Mathur N (2015) Introduction: Remaking the Public Good. *The Cambridge Journal of Anthropology* 30(1): 18-34.

Bivins R (2010) *Alternative Medicine?: A History*. New York: Oxford University Press.

Butter I (1971) The Migratory Flow of Doctors to and from the United States. *Medical Care* 9: 17–31.

Butter, I and Schaffner R (1971) Foreign Medical Graduates and Equal Access to Medical Care. *Medical Care* 9:136–143.

Butter I and Sweet R (1977) Licensure of Foreign Medical Graduates: An Historical Perspective. *The Milbank Memorial Fund Quarterly. Health and Society* 55(2): 315–340.

Bowker G and Star S (2000) *Sorting Things Out: Classification and Its Consequences*. Boston: The MIT Press.

Das V and Poole D (2004) State and Its Margins: Comparative Ethnographies. In: Das V and Poole D (eds) *Anthropology in the Margins of the State*. Santa Fe: School of America Research Press, pp. 3-34.

Das Gupta M (2006) *Unruly Immigrants: Rights, Activism, and Transnational South Asian Politics in the United States*. Durham: Duke University Press.

Douglas M (1986) *How Institutions Think*. Syracuse: Syracuse University Press.

Escobar A (2011) *Encountering Development: The Making and Unmaking of the Third World*. Princeton: Princeton University Press.

Fanon F (2008) *Black Skin, White Masks, Revised edition*. New York: Grove Press.

Fassin D (2001) *Humanitarian Reason: A Moral History of the Present*. Berkley: University of California Press.

Ferguson J (1994) *The Anti-Politics Machine: Development, Depoliticization, and Bureaucratic Power in Lesotho*. Minnesota: University of Minnesota Press.

Fleck, L (1981) *Genesis and Development of a Scientific Fact*. Chicago: University Of Chicago Press.

Forman P (1987) Behind Quantum Electronics: National Security as Basis for Physical Research in the United States, 1940-1960. *Historical Studies in the Physical Sciences* 18: 149-229.

Foucault M (1982) *The Archaeology of Knowledge: And the Discourse on Language*. New York: Vintage Books.

Foucault M (1995) *Discipline & Punish: The Birth of the Prison*. New York: Vintage Books.

Foucault M (1994) *The Order of Things: An Archaeology of the Human Sciences, Reissue edition*. New York: Vintage Books.

Foucault M (2003) *Society Must Be Defended: Lectures at the College de France, 1975-1976*. New York: Picador.

Frohock FM (1995) *Healing Powers: Alternative Medicine, Spiritual Communities, and the State*. Chicago: University Of Chicago.

Golash-Boza TM (2012) *Immigration Nation: Raids, Detention and Deportation in Post 9/11 America*. New York: Routledge.

Golash- Boza TM (2017) *Forced Out and Fenced In: Immigration Tales From the Field*. London: Oxford University Press.

Gupta A (2012*) Red Tape: Bureaucracy, Structural Violence, and Poverty in India*. Durham: Duke University Press.

Hacking I (1982) Biopower and the Avalanche of Printed Numbers. *Humanities in Society* 5: 279-295.

Hallock J (2006) Celebrating 50 Years of Experience. *Academic Medicine* 81: 57-59.

Heimer C (2006) Conceiving Children: Bow documents Support Case Versus Biographical Analysis. In: Riles A (ed) *Documents: Artifacts of Modern Knowledge*. Ann Arbor: University of Michigan, pp. 95-126.

Hetherington K (2011) *Guerilla Auditors: The Politics of Transparency in Neoliberal Paraguay*. Durham: Duke University Press.

Hondagneu-Sotelo P (2008) *God's Heart Has No Borders: Religious Activism for Immigrant Rights*. Los Angeles: University of California Press.

Hull M (2012) *Government of Paper: The Materiality of Bureaucracy in Urban Pakistan*. Berkeley: University of California Press.

Jasanoff S (2006) Biotechnology and Empire: The Global Power of Seeds and Science. *Osiris* 21: 273–292.

Johnson D and Chaudhry HJ (2012) *Medical Licensing and Discipline in America: A History of the Federation of State Medical Boards.* Lanham: Lexington Books.

Johnston RD (2004) *The Politics of Healing: Histories of Alternative Medicine in Twentieth-Century North America.* New York: Routledge.

Jones G (2016) "A Mysterious Discrimination": Irish Medical Emigration to the United States in the 1950s. In: Monnais L and Wright D (eds) *Doctors beyond Borders: The Transnational Migration of Physicians in the Twentieth Century*. Toronto: University of Toronto Press, pp. 96-117.

Kevles D (1990) Cold War and Hot Physics: Science, Security, and the American State, 1945-56. *Historical Studies in the Physical and Biological Sciences* 20(2): 239-264.

Latour B (2007) *Reassembling the Social: An Introduction to Actor-Network-Theory*. London: Oxford University Press.

Lowe L (1996) *Immigrant Acts: On Asian American Cultural Politics*. Durham: Duke University Press.

McKay R (2012) Documentary disorders: Managing medical multiplicity in Maputo, Mozambique. *American Ethnologist* 39: 545–561.

Ngai M (2014) *Impossible Subjects: Illegal Aliens and the Making of Modern America.* Princeton: Princeton University Press.

Porter R (2003) *Quacks - Fakers & Charlatans in Medicine*. Stroud: Tempus Publishers.

Povinelli E (2002) *The Cunning of Recognition: Indigenous Alterities and the Making of Australian Multiculturalism*. Durham: Duke University Press.

Riles A (2006) Introduction: In response. In: Riles A (ed) *Documents: Artifacts of Modern Knowledge*. Ann Arbor: University of Michigan, pp. 1-40.

Robins N (2005) *Copeland's Cure: Homeopathy and the War Between Conventional and Alternative Medicine*. New York: Knopf Publishers.

Roy H (2016) Paper Rights: The Emergence of Documentary Identities in Post-Colonial India, 1950–67. *South Asia: Journal of South Asian Studies* 39: 329–349.

Scott J (1999) Seeing like a State: How Certain Schemes to Improve the Human Condition Have Failed. New Haven: Yale University Press.

Silverblatt I (2004) *Modern Inquisitions: Peru and the Colonial Origins of the Civilized World*. Durham: Duke University Press.

Starr P (1984) The Social Transformation of American Medicine: The rise of a sovereign profession and the making of a vast industry. New York: Basic Books.

Splisbury J and Cooney M (1998) Immigrant Health Care Providers in the United States. In: Loue S (ed) *Handbook of Immigrant Health*. New York: Springer, pp. 607-628.

Steil B (2013) The Battle of Bretton Woods: John Maynard Keynes, Harry Dexter White, and the Making of a New World Order. Princeton: Princeton University Press.

Stevens R et al (1978) *Alien Doctors: Foreign Medical Graduates in American Hospitals*. New York: John Wiley & Sons Inc.

Stoler A (2010) Along the Archival Grain: Epistemic Anxieties and Colonial Common Sense. Princeton: Princeton University Press.

Taylor C (1994) The Politics of Recognition. In: Gutmann A (ed*) Multiculturalism: Examining the Politics of Recognition*. Princeton: Princeton University Press, pp. 25-74.

Ticktin M (2011) *Casualties of Care: Immigration and the Politics of Humanitarianism in France*. Berkeley: University of California Press.

US Congress (1968) *Brain Drain of Scientists, Engineers, and Physicians from the Developing Countries Into the Unites States.* Hearing before the House Committee on Government Operations, Second Session, 23 January. Washington: US Government Printing Office.

US Congress (1974) *Health Manpower.* Hearing before Senate Committee on Labor and Public Welfare, Second Session, 24 June. Washington: US Government Printing Office.

US Congress (1977) *Foreign Medial Graduates*. Hearing before the House Subcommittee on Immigration, Citizenship, and International Law, First Session, 24 March. Washington: US Government Printing Office.

US Congress (1988) *Health Manpower*. Hearing before the House Subcommittee on Health and Environment, Second Session, 19 January. Washington: US Government Printing Office.

Weber M (1978) *Economy and Society: An Outline of Interpretive Sociology*. Berkeley: University of California Press.

Weld K (2014) *Paper Cadavers: The Archives of Dictatorship in Guatemala*. Durham: Duke University Press.

Weiss RJ et al. (1974) Foreign Medical Graduates and the Medical Underground. *New England Journal of Medicine* 290: 1408–1413.

Whorton JC (2004) *Nature Cures: The History of Alternative Medicine in America*. London: Oxford University Press.

Woolgar S and Neyland D (2014) *Mundane Governance: Ontology and Accountability*. London: Oxford University Press.

Wright D et al (2016) Draft Doctors: The Impact of the Vietnam War on the Migration of Foreign Doctors to Canada. In: Monnais L and Wright D (eds) *Doctors beyond Borders: The Transnational Migration of Physicians in the Twentieth Century*. Toronto: University of Toronto Press, pp. 166-184.

Young JH (1967) *The Medical Messiahs: a Social History of Health Quackery in Twentieth-Century America*. Princeton: Princeton University Press.

Zeitlyn D (2012) Anthropology in and of the Archives: Possible Futures and Contingent Pasts. *Annual Review of Anthropology* 41: 461–480.

Zolberg A (2008) *A Nation by Design: Immigration Policy in the Fashioning of America*. Cambridge: Harvard University Press.

(1954) Alien Doctors Reduce Standards in Nation, Columbia Dean Charges. *The New York Times,* 8 Feb. Available at: http://query.nytimes.com/mem/archive/pdf?res=9C02E2DB153CE43ABC4053DFB466838F649EDE (accessed 10 July 2015).

(1976) Fake Doctor From India Performed Brain Surgery. *The Chicago Sun-Times*, 6 May (accessed 17 May 2014).