The Care of Foreigners:
How Immigrant Physicians Changed US Healthcare


Eram Alam, PhD

BALTIMORE, MD — Nearly one in four doctors in the United States (US) are foreign-born and they often serve in rural and underserved urban communities. *The Care of Foreigners: How Immigrant Physicians Changed US Healthcare* by **ERAM ALAM, PhD**, reveals the hidden backbone of American medicine: the immigrant doctors who have long shouldered the care of patients in these areas. Alam traces the global and domestic forces that fostered this dependency.

The author is an assistant professor in the Department of the History of Science at Harvard University. She specializes in the history of medicine, with a particular emphasis on globalization, race, migration, and health during the 20th century.

The following is an edited excerpt of a Q&A with the author that was sent to RIMJ by the publisher.

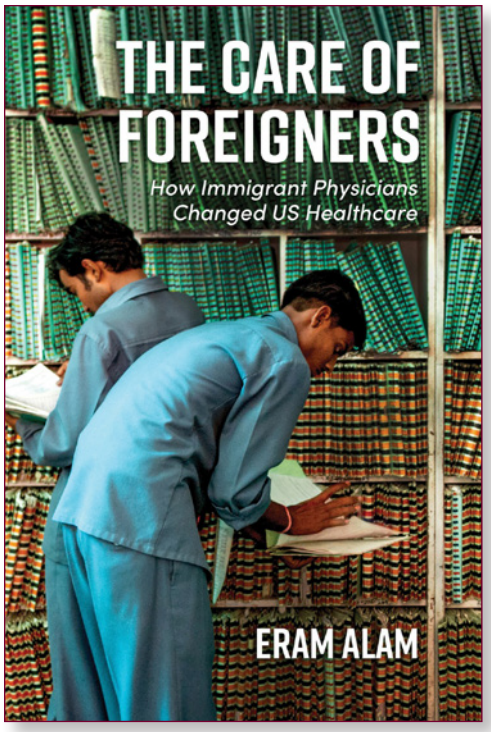
Q&A with Eram Alam

Q: *The Care of Foreigners* explores a paradox at the intersection of healthcare and immigration: Americans vilifying immigrants rarely mention the hundreds of thousands of foreign-born doctors the country depends on in medically underserved communities. How do doctors integrate into places where they are both desperately needed and looked at with suspicion?

A: This paradox highlights the gap between political rhetoric and practical reality. As in many sectors of society, immigrants perform essential jobs that many Americans are either unwilling or unqualified to do – and physicians are no exception. Foreign-born doctors provide care in communities long neglected by the US medical system. Based on my research, they are often accepted in places that might otherwise be suspicious of immigrants, simply because these communities have no other options. In many rural areas where Americans are on average sicker and farther from regular healthcare, access to any medical provider – regardless of immigration status – is better than no care at all. While initial social acceptance can be a challenge, many doctors reported eventually gaining trust by consistently offering quality care and becoming visible through community outreach and philanthropy.

Q: You begin the book with the story of Nayan Seth who emigrated from the city of Pune, India to Akron, Ohio in 1968. Why is his experience emblematic of so many other foreign doctors? And in what ways is Akron representative of the many communities immigrant doctors enter every year?

A: Akron, Ohio, once thrived as the "Rubber Capital of the World," home to industrial giants like Goodyear and Firestone. But by the late 1960s and 1970s, deindustrialization and globalization triggered massive job losses, population decline, and worsening public health outcomes. As local hospitals struggled to meet growing demand amid financial strain, cities like Akron became less appealing to American medical graduates seeking stable, well-resourced environments. Into this gap stepped immigrant physicians like Nayan Seth, who was trained in India and arrived in Oho ready to work as a resident physician. His decision to practice in Akron reflects the kinds of opportunities offered to these physicians: providing care in underserved urban, postindustrial, and rural communities. Akron is representative of many such places across the US – economically distressed yet deeply reliant on the expertise and commitment of foreign-trained physicians



The Care of Foreigners by Harvard Associate Professor **Eram Elam, PhD**, was released by the Johns Hopkins University Press on Oct. 14, 2025. [PHOTOS COURTESY OF JOHNS HOPKINS UNIVERSITY PRESS]

Q: The book focuses primarily on Indian doctors who have immigrated to America. Such an exodus doesn't happen in a vacuum; how has India's healthcare system been affected by so many of its young doctors practicing abroad?

A: India's healthcare system has been significantly strained by the emigration of its doctors, especially as the country continues to face a high disease burden with limited medical infrastructure. While the US has 26 doctors per 10,000 people, India has fewer than nine – despite being the top contributor of foreign doctors to the United States. India felt this disparity sharply during the COVID-19 pandemic when its states struggled to provide adequate care due to physician shortages, even in places where hospital beds were available. The outflow of trained professionals exacerbates inequality between wealthier states like Kerala

and under-resourced regions like Bihar. In response, India has attempted to curb emigration through bureaucratic policies, such as penalizing doctors who skip service in public hospitals or requiring return commitments for those training abroad. However, enforcement remains uneven, particularly for privileged groups who can evade these rules, leaving India's healthcare system vulnerable to chronic understaffing.

Q: Foreign-born doctors hail from many nations, each with its own medical accreditations and educational systems. How do these doctors navigate the American medical bureaucracy when they arrive here? Are there any differences in their education and prior experience that affect their practice in the United States?

A: Immigrant physicians face a complex and onerous path to practice when entering the United States. Regardless of prior education or experience, they must pass the United States Medical Licensing Examination (USMLE), secure residency training – even if they were already practicing physicians in their home country – and obtain a state-specific license to practice. These physicians often rely heavily on friends and colleagues who came before them to help them navigate entry into a new professional and personal life. While all are trained in a Western biomedical paradigm, their clinical knowledge was shaped within a distinct social and cultural context. When transferred to the US, they must reassemble that biomedical knowledge to fit a medical system with its own tacit practices, language norms, and patient expectations. Their journey requires persistence and agility when navigating a system built for US-trained physicians.

Q: For decades the United States has recruited foreign doctors rather than bolster its health infrastructure, depriving other countries of their most promising medical talent. For American politicians or medical administrators, what are the ethical considerations when weighing one's duty to a medically underserved area against essentially outbidding other countries for their doctors? And what would an alternative solution to this longstanding issue look like?

A: The United States' reliance on foreign-trained physicians raises complex ethical questions. On one hand, filling shortages in medically underserved areas is vital; on the other, recruiting doctors from countries with even fewer healthcare resources deepens global health inequities. US policymakers must weigh their duty to domestic communities against their impact on global health systems. Outbidding low- and middle-income countries for top medical talent contributes to "brain drain," a critique raised as early as the immigration debates preceding the 1965 legislation that enabled this migration regime. An ethical and sustainable alternative would reduce dependence on international recruitment by addressing workforce shortages at their root. This includes expanding US medical school and residency slots, offering incentives for students from rural or marginalized communities, and investing early in STEM education and medical school affordability. Strengthening public health infrastructure and broadening care roles, such as through nurse practitioners or community health workers, can also reduce strain. And finally, offering licensure pathways to immigrant physicians already in the country ensures existing talent is not wasted while easing pressure to recruit abroad. ❖