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State Xenophobia?

“Foreign Doctors” in France (1945–2006)

Marc-Olivier DÉPLAUDE

Abstract – Xenophobia lay behind the legal barriers set up between the late nineteenth century and the 1930s to deter doctors from outside France (“foreign doctors”) from practicing medicine in France. Does this mean that xenophobia as embedded in law was the principal reason that doctors from the former French colonies and protectorates were kept in low-status jobs within the medical field, reinforced by public policy, up until the regulatory measures of the late 1990s? Using sociological and historical materials, this paper provides some answers to this question by analyzing changes in the situation of foreign doctors and in the debate and measures related to this issue between the postwar years and the mid-2000s.

At the end of the nineteenth century, French doctors began action to limit medical practitioners from outside France (so-called “foreign doctors”) from working in the profession in France. In 1892, they succeeded in limiting access to holders of France’s state diploma of doctor of medicine (*docteur en médecine*). In 1896, diplomas were introduced for foreigners that did not entitle holders to practice in France. Later, in 1933, a vote was pushed through on a law introducing the additional requirement of French citizenship. In 1935, at the request of French doctors, another law introduced a complex system of penalties aimed at delaying the setting up of naturalized doctors who had not performed French military service, even those who were ineligible for service for reasons of sex, health, and age. These successive actions were accompanied by overtly xenophobic discourse.¹ Foreign-born doctors were collectively accused of causing a glut in the profession, and of taking jobs that rightly belonged to French nationals. This was presented as being all the more harmful to the public good, on top of allegations that foreign doctors lacked the moral fiber required to practice medicine and had a mercenary attitude toward the profession.²

Until the beginning of the 1970s, the medical profession was thereby virtually closed to doctors who did not possess the French diploma and French citizenship. However, from the 1970s, and in the 1980s in particular, public hospitals began to employ foreign doctors in positions left unfilled by French nationals. The vast majority were doctors from former French colonies and protectorates. As it was rare to receive authorization to work in the self-employed sector, thousands of foreign doctors accepted these hospital positions, despite precarious conditions and poor pay. At the end of the 1990s, following heated debate, the French government finally granted approximately 8,000 foreign doctors the same right to practice as French nationals, thereby giving them access to the self-employed sector and all salaried employment.

Xenophobia lay beneath the legal barriers set up between the late nineteenth century and the 1930s to deter foreigners from practicing medicine in France. Does this mean that xenophobia as embedded in law was the principal reason that doctors from former French colonies and protectorates were restricted to low-status jobs within the medical field, reinforced by public policy, for as long as they were—that is, up until the new regulatory measures of the late 1990s? Can we, in other words, describe this situation as a direct product of the state xenophobia openly expressed in the 1930s (and even after the war³) by the medical profession?

1. *Xenophobia* is defined here as categorizing individuals according to their actual or supposed nationality, and attributing negative characteristics to their groups or presenting them as a menace to other groups. This definition is largely based on Robert Miles and Malcolm Brown, *Racism* (second edition) (London: Routledge, 2003).

2. Regarding these movements, see notably Donna Evleth, “Vichy France and the Continuity of Medical Nationalism,” *Social History of Medicine* 8 (1) (1995); and Gérard Noiriel, *Immigration, antisémitisme et racisme en France (XIX^e–XX^e siècle)*. *Discours publics, humiliations privées* (Paris: Fayard, 2007).

3. Evleth, *Vichy, France and the Continuity*.

This paper will attempt to provide some answers to this question. We will analyze changes in the situation of foreign doctors in France (and various debates and policies surrounding them) between the postwar period and the mid-2000s. Two main assumptions inform this approach. The first, derived from Robert Miles and Malcolm Brown's analyses of racism, posits that xenophobia cannot be presumed solely on the basis of discrimination against foreigners;⁴ that a number of factors may be at its source, thus requiring an empirical approach. The second assumption relates to the medical profession and the French government, which we consider here as segmented wholes, each characterized by numerous internal struggles that follow their own rationale. This may seem to be an obvious statement, yet criticism of postcolonial studies has shown that many works tend to portray the state as a monolith and to underestimate the internal struggles within social, administrative, and political elites.⁵ This has led certain authors to postulate that members of these elites were motivated by a single xenophobic or racist worldview that was the driving factor behind colonial policies.⁶

Thus, we will present the following argument: that the situation endured by doctors from France's former colonies and protectorates until the 1990s was the result of several features of sociohistorical dynamics, and not just xenophobia; similarly, that public policy on foreign doctors resulted from compromises between often incompatible interests, sometimes with outcomes not sought by any of the parties involved.

This paper is organized into three main parts. First, we present the way in which the legal system as applied to foreign doctors, or to doctors with foreign qualifications, implemented changes between the postwar period and the 1980s. Second, we examine how the public hospitals came to recruit large numbers of doctors with diplomas from outside the European community from the 1980s to 1990s. Third, we consider the reaction to this recruitment within the medical profession, and the subsequent measures taken by government authorities concerning them.⁷

4. Miles and Brown, *Racism*.

5. Romain Bertrand, "Les sciences sociales et le 'moment colonial': de la problématique de la domination coloniale à celle de l'hégémonie impériale," CERI, *Questions de Recherche* 18 (2006); Jean-François Bayart, *Les études postcoloniales. Un carnaval académique* (Paris: Karthala, 2010); Emmanuelle Saada "Coloniser, exterminer: sur la guerre et l'État colonial" [lecture notes], *Critique Internationale* 32 (2006).

6. Olivier Le Cour Grandmaison, *La République impériale : politique et racisme d'État* (Paris: Fayard, 2009); see the review of this work by Simon Jackson for *La vie des idées*, <http://www.laviedesidees.fr/Liberte-egalite-fraternite-empire.html>.

7. This article is based upon various sources: public and private archives; legal texts and circulars; parliamentary debates; documents produced by trade organizations or other actors mobilized around the issue of doctors with non-European diplomas; professional journals and bulletins; general press; semi-structured interviews with state employees and doctors; etc. As space is limited here, we are unable to give more details on the way in which we gathered our sources, but see our PhD dissertation in political science, *L'emprise des quotas. Les médecins, l'État et la régulation démographique du corps médical (années 1960–années 2000)*

From National to European Closure

Legal Regulation under the Governmental Order of September 24, 1945

A law promulgated on September 24, 1945, applicable to practitioners who did not meet the general guidelines on citizenship and diplomas for practicing medicine, enforced the same regulations as those in force before the war. The exception were the specific conditions for naturalized doctors, which were abolished.

Applied in close consultation with the *Ordre des médecins*⁸ and the main doctors' union at the time, the Confederation of French Physicians Unions (*Confédération des syndicats médicaux français*—CSMF), this regulation was subject to several derogations, some of which dated back to before the war. These mostly were about citizenship. As of the 1930s, agreements were made with other European countries, such as Romania and Italy, to exempt them from the requirement of citizenship. When France's colonies started to gain independence from the mid-1950s, similar agreements were signed with the newly independent states. At the beginning of the 1960s, the exemption from French citizenship enjoyed by Moroccans and Tunisians was even included in the French public health code.

Exemptions for the diploma, however, were granted very sparingly. Some were granted as part of agreements signed with neighboring countries. Entered into with Luxembourg (1879), Switzerland (1889), and Belgium (1910), they authorized doctors established in these countries to practice in neighboring French towns, on the condition that no French doctors resided there (and vice versa). Further, while permitted to practice medicine in France, these foreign nationals could not establish offices there. They had to give up their French patients if a French doctor arrived in town. These terms were strictly applied. In 1956, regarding a petition from the residents of a French town neighboring Belgium, demanding that a Belgian doctor be allowed to continue treating them despite the arrival of a French doctor in their area, the Secretary of State for Public Health and Population reminded the prefect of the Nord department

(Université Paris 1, 2007). During the investigation, part of the archives consulted were handed over to the Ministry of Health's archives unit, but had not yet been passed to the Center for Contemporary Archives (CAC—*Centre des archives contemporaines*). These intermediate archives (IA) will therefore be referred to under their provisional index number already assigned to them. Unless otherwise stated, statistical data quoted comes from the Ministries of National Education and Health. At various stages, this article benefited from judicious comment and advice from Florent Champy, Patrice Pinell, and participants at the summer school organized by my colleagues of the research unit RiTME (French National Institute for Agricultural Research) in Porquerolles in June 2010. Heartfelt thanks to them here.

8. Founded by the Vichy government in 1940, the *Ordre des médecins* is a jurisdictional institution, which is in charge of elaborating and implementing the deontological code of the medical profession. Doctors can practice medicine only if they are members of the *Ordre*.

that the Franco-Belgian agreement was “an *exceptional* regulation.”⁹ The petition was rejected with no further action.

A new possibility for exemption from the diploma requirement was introduced by a French law promulgated on June 9, 1949. When a foreign state granted French doctors the right to practice medicine in its territory, its citizens could be reciprocally authorized to practice in France. There had to be a signed bilateral agreement and recognition that the foreign state’s diploma was equivalent to the French diploma. Further, under this law, qualifying foreign doctors had to pass examinations—on French general culture and French medical and social legislation. Lastly (and importantly), agreements entered into under this law included a set number of practitioners authorized to work in each country. This ensured “effective parity.” Authorizations of doctors were thereby granted one at a time, alternating between the two states, ensuring effective parity, with equal numbers of authorized doctors exchanged until the agreed quota was filled.

These agreements, which were always the subject of prior consultation with the *Ordre des médecins* and the CSME, only concerned a small number of practitioners. A February 1967 letter from the Sub-Department of Health Professions to the Ministry of Foreign Affairs stated that such “reciprocal agreements” were signed with Colombia and Peru, but that these were entered into following a simple “exchange of notes,” in view of their “limited scope.”¹⁰ An agreement with Spain in 1968 is another example. It involved only one doctor from each country and when renewed in 1973 was extended to include only four more doctors. This demonstrates the limited effect of such agreements on the medical profession.

It was possible for foreign doctors who did not benefit from these agreements to have their diplomas converted to the French medical diploma. The conditions required to do this, however, were dissuasive. They would only be exempted from the first three years of medical studies, out of a total of six, and were required to take examinations corresponding to the years from which they were exempted.

The diploma was the largest obstacle for foreign doctors to practice medicine in France, far more so than the French citizenship requirement. In contrast to the prewar years, the main concern of the medical profession was not the foreigners who studied medicine in France, but foreign doctors who had received their initial training abroad. Indeed, no doubt because the stream of students from Central Europe ended, and medical training in France’s former colonies and protectorates expanded, the proportion of foreigners among medical students in France dropped sharply after the prewar years. In 1967, foreigners

9. IA DHOS/2002/012. Underlined in the original document.

10. IA DHOS/2002/012.

represented just 8.5 percent of medical students, compared with 24 percent in 1933. The opening up of the medical profession to foreign practitioners in the 1970s therefore mainly concerned doctors trained outside of France.

Limited Opening Up in the 1970s

Changes affecting how doctors with foreign diplomas were received in France during the 1970s did not result from internal developments within the medical profession, but from outside pressure, which came first from the Ministry of Foreign Affairs. Basing its argument on the New York Protocol of 1967, which extended the Geneva Conventions to refugees from non-European countries, the Ministry of Foreign Affairs asked the Ministry of Health to adopt provisions that would enable stateless or refugee doctors to practice in France. On July 13, 1972, the French government promulgated a law that established a consultative commission charged with granting individual authorizations for full rights to practice, within a quota set by the minister of health. Candidates would have to have their diplomas recognized as equivalent to France's state diploma in medicine and also pass various aptitude tests.

The adoption of this law met with strong resistance from the *Ordre des médecins*, which had already successfully opposed a first draft law on the matter in 1965. The *Ordre* was concerned by the very rapid growth in numbers of medical students, which increased from 31,500 in 1960–61 to 54,700 in 1966–67, following a period of near stagnation during the 1950s.¹¹ The number of students enrolled for the first year of preparation for medical studies alone increased by 60 percent between 1965–66 and 1967–68. Following the events of May 1968, which affected both medical schools and teaching hospitals, the *Ordre des médecins*, along with other professional bodies, requested the setting up of a quota system, or *numerus clausus*, to limit the number of students beginning medical studies. Their request was met in 1971. The authorities were also concerned by the impact of uncontrolled growth in the number of doctors on public health insurance spending.¹² The *numerus clausus*, which was put into effect via the introduction of competitive examinations at the end of the first year of medical studies, led to a progressive reduction in the number of medical students.

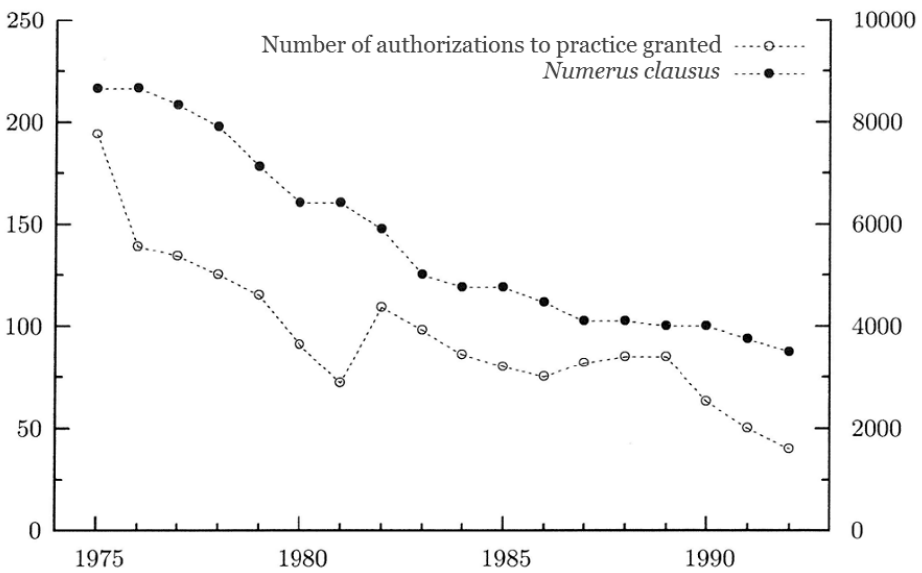
In this context, France had to limit the number of authorized doctors trained abroad. For the professors of medicine seated on the practice authorizations commission, which began meeting in March 1975, there was no question of granting too many authorizations. This was both for reasons of fairness to medical students who failed the end-of-first-year competitive examination and protecting the interests of foreign states who had provided initial training for their

11. These figures also include students enrolled to study dentistry.

12. Marc-Olivier Déplaude, "Instituer la 'sélection' dans les facultés de médecine. Genèse et mise en œuvre du *numerus clausus* de médecine dans les années 68," *Revue d'Histoire de la Protection Sociale* 2 (2009).

doctors.¹³ For representatives of the *Ordre des médecins* and the self-employed practitioners’ unions, these authorizations also had to be granted sparingly, due to the arrival of large numbers of newly qualified medical doctors in the labor market at a time when the government’s stated aim was to contain growing healthcare costs. In 1976, the members of the commission agreed to keep the number of authorizations granted each year to the *numerus clausus* for medical studies, so as to not exceed 1 percent of the latter. The commission granted 194 authorizations to practice in 1975, but only 72 in 1981 (see figure 1).

Figure 1 – Changes in the *numerus clausus* and the annual individual authorization-to-practice quota between 1975 and 1992



Source: Official Journal of the French Republic (Journal Officiel de la République Française)

Incorporating into French law the European directives of June 16, 1975, drew much less resistance from the medical profession. The directives applied the 1957 Treaty of Rome guidelines for the free circulation of people and services to medical doctors.¹⁴ It was expected that migration of doctors within the EEC

13. As was reported by a professor of medicine during a meeting of the commission in 1976, “France was criticized at the convention of French language UFRs [*unité de formation et recherche*; training and research units] recently held in Marseille, where it was declared that doctors from developing countries would settle down in France after doing their studies there and would thereby help to fulfill the requirements of our country [. . .]. In doing so, France would be employing a policy of despoilment rather than cooperation vis-à-vis its former overseas territories” (CAC 2001284).

14. The Treaty of Rome led to the establishment of the European Economic Community (EEC), or the “Common Market,” comprising six states in Western Europe: Belgium, France, Italy, Luxembourg, the

would either be limited or compensate for each other. As of January 1, 1977, practitioners from an EEC member state were thereby allowed to practice in France without prior authorization.

Before the European Union expanded to include Eastern European countries in 2004 and 2007, the 1975 European directives had limited effect on migration.¹⁵ They however brought about a new type of discrimination. Doctors from EEC member states acquired the same right to practice as doctors trained in France, whereas doctors from outside the EEC had to obtain prior authorization, which, as we have seen, the commission granted very sparingly.

By the end of the 1970s, for doctors trained outside of the EEC, prospects for practicing medicine in France were still very limited. Even so, doctors at teaching hospitals, some of whom kept regular contact with their French-speaking counterparts in Mahgreb, the Near East, and Sub-Saharan Africa, encouraged the arrival of doctors wishing to receive additional training in France. These doctors, whose status varied, were entrusted with the same responsibilities in hospitals as French medical residents, that is, medical students who had passed the competitive examination for residency, most but not all of whom were being trained in a specialist area. As hospitals faced recruitment difficulties in certain disciplines, they were authorized to hire doctors who did not satisfy the general conditions to practice medicine. These doctors typically were practitioners who had passed the aptitude tests provided for by the July 13, 1972, law (or were exempted from them) and hoped to obtain full authorization to practice. However, until the beginning of the 1980s, there were few vacant positions for these doctors. Most were filled by residents and students studying for the French state diploma in great numbers at the time, due to a high *numerus clausus* and the fact that there was little regulation of access to specialized training.

Hospitals under Constraint

Confronted with a growing lack of medical personnel starting in the 1980s, public hospitals recruited many doctors with non-EEC diplomas, under the guise of training, in order to ensure the operation of their services. The National Academy of Medicine (*Académie nationale de médecine*), and later the Ministry of Health, attempted to measure the scale of these recruitments. According to censuses conducted between 1993 and 1995, nearly 8,000 doctors with non-EEC diplomas were working in public hospitals—in particular in general

Netherlands, and West Germany. Other European countries joined subsequently (e.g., the United Kingdom in 1973) and the EEC expanded in other significant ways. The EEC was renamed the European Union (EU) in 1993 and today comprises 28 Western, Eastern, and Central European states.

15. Léon Hurwitz, "La libre circulation des médecins dans la communauté européenne. Le cas de la France," *Revue Française des Affaires Sociales* 42 (3) (1988).

hospitals in unappealing geographical locations.¹⁶ The importance acquired by these doctors in the operation of hospital services during the 1980s and 1990s was the result of several sociohistorical trends, of which the main ones will be discussed here.

A Lower Numerus clausus and Reform of Specialized Studies

The recruitment by public hospitals of doctors with non-EEC diplomas was primarily due to a fall in the number of doctors training in France. This resulted from the lowered *numerus clausus* and reform of medical studies in 1982, intended to improve the training of future specialists while limiting access to the title of specialist.

As of 1977, the authorities began to reduce the *numerus clausus* for medical studies that had been introduced six years earlier. The quota decreased from 8,671 in 1977, to 6,409 in 1981, and then fell below the 4,000 level in 1992. This policy was very strongly supported by self-employed medical practitioners' unions, which faced a strong increase in the number of people working in the medical profession, which came directly from the increase in the number of medical students a decade earlier. Between 1975 and 1984, the number of practicing doctors increased from 81,000 to 140,000. For those in charge of the public health insurance, the *numerus clausus* was seen as a means of controlling spending—the fewer doctors trained by universities, the lighter the burden on the public health insurance budget.¹⁷ At the same time, the government wanted to limit specialists and have a higher proportion of trained general practitioners (GPs), whose costs for treatments were lower. This policy was also supported by self-employed specialist practitioners' unions, which had seen a rapid worsening in the material situation of specialists since the middle of the 1970s.

However, until the beginning of the 1980s, there was little regulation of specialized medical studies. Up until this point there were two main ways of becoming a medical specialist. The most selective and prestigious of these was to take the competitive residency examination organized by teaching hospitals, known as CHUs (*Centres hospitaliers et universitaires*). CHU residents were paid, entrusted with various responsibilities, and fulfilled numerous ward and standby duties. Upon successful completion of their residencies, they were awarded equivalent qualifications in the form of one or more specialized study

16. Danielle Rigaudiat, *Les médecins en provenance d'un pays hors CEE dans l'hôpital public* (Paris: Fondation de l'Avenir, 1990). Their numbers were probably greater, as it was difficult taking census of doctors in precarious positions, and some places did not reveal their employment, to avoid alerting the Ministry of Health of illegal situations. Nor do the figures include doctors holding non-medical positions and employed as healthcare assistants or nurses (see below).

17. All French doctors holding a state diploma and registered with the *Ordre des médecins* can be covered by the French public health insurance system. This means, in particular, that their fees and prescriptions can be reimbursed by Social Security and complementary health insurance policies.

certificates (*Certificats d'études spéciales*—CES), depending in the courses they had taken. The other, much less selective way involved studying directly for a CES. Unlike CHU residents, enrolled CES students were not automatically entitled to responsibilities in a hospital, although the vast majority of them did undergo training in a hospital, generally working as FFIs (*faisant fonction d'interne*¹⁸), or as health region residents if they had passed one of the competitive residency examinations organized by general hospitals.¹⁹ In 1978, for 4,300 CHU resident positions, there were 2,600 health region resident positions and 3,700 FFI positions. Two-thirds of the latter were in general hospitals.²⁰ At the end of the 1970s, a large number of trainee doctors were therefore received in general hospitals, the large majority of whom were in specialist study.

The reform of 1982, implemented in 1984–1985, consisted of combining all existing competitive residency examinations into a single national exam and making this the only way to access specialized training. The new residency examination thereby strictly limited access to specialized medicine, with access to specialist training henceforth depending in quota limits. Students who failed the examination would become GPs following two years of practical training. The reform stipulated that future specialists be trained in teaching hospitals, future GPs principally in general hospitals. Yet the proportion of residents and FFIs was greater in general hospitals before the reform. In 1976, they represented 48 percent of doctors working in these hospitals at full-time equivalent, compared with 31 percent in CHUs.

By concentrating the training of specialists in CHUs, the 1982 reform removed trainee specialists from general hospitals in dire need of them from the mid-1980s. The CHUs, which were spared these difficulties to begin with, suffered from the effects of the progressive reduction in the number of places offered for the competitive residency examination a few years later. The number of available places dropped by 20 percent between 1985 and 1995, with a sharper decrease for hospitals in the Paris region and in the south of France.

Decreasing Attractiveness of Hospital Careers

The reduction in the number of doctors being trained (GPs and specialists) had an even greater effect on hospitals as their need for practitioners increased. The generalization of full-time hospital medicine, following the 1958 reform of hospitals and universities, led to an intensified medical work in hospital environments. The length of stay of hospital inpatients was shortened, while tasks that were previously performed by trainee practitioners or other categories of

18. FFI did the job of a resident, without holding the title of resident and with a lower pay.

19. For certain disciplines, there were also specific competitive residency examinations, such as those for the psychiatry and ophthalmology residencies at *Hôpital des Quinze-Vingt* in Paris.

20. Memo from the planning office (*Bureau des études et du plan*) of the General Health Service Department (*Direction générale de la santé*—DGS), October 1978, private archives.

healthcare staff now had to be performed by attending staff.²¹ Numerous hospital practitioner positions were created. However, the creation of these positions did not entirely compensate for the reduction in the number of doctors being trained, and the positions created were also very difficult to fill, particularly in general hospitals. The number of statutorily vacant positions, i.e. positions that were budgeted for but not filled by doctors having passed the competitive hospital exams, began to increase. In 1985, a survey conducted by the French Hospitals Department showed that there were 900 vacant hospital doctor positions (out of 6,900) in general hospitals. In 1989, there were 2,282 in all public hospitals, of which 1,766 were in general hospitals.

These difficulties were linked to the medical studies reform, which led to a sharp drop in the number of doctors trained in certain specialties and an increasing scarcity of candidates for positions in hospitals. But, to an even greater extent, they were due to a loss of prestige in hospital careers. The vast majority of doctor positions created in public hospitals from the end of the 1970s were in general hospitals. Between 1978 and 1995 the proportion of doctors working in general hospitals increased from 30 percent to 58 percent of all full-time hospital practitioners. The vast majority of new jobs were *mono-appartenant*, i.e. positions in hospitals only, and not *bi-appartenant*, i.e. positions in both a hospital and a university. *Mono-appartenant* positions were less prestigious than *bi-appartenant* positions, and they were less well paid. As a result, competition was greater for *bi-appartenant* positions, which also meant more difficult working conditions in early career, and more uncertain career prospects. These changes explain why, for many young doctors, working as a self-employed practitioner could appear more attractive in terms of conditions and income than working in hospitals. Significantly, it was in the more lucrative specializations in the self-employed sector (such as radiology, surgery, and anesthesia and resuscitation), and in rural locations or deprived suburbs of large towns, that hospital positions were the hardest to fill.

Doctors Prepared to Accept Demanding Positions

In the face of these recruitment difficulties, regulations allowed public hospitals to hire doctors with non-EEC diplomas by reallocating the amounts budgeted for positions not taken up by residents or hospital practitioners. Nearly all doctors recruited in this way were employed as FFIs, associate sessional doctors, or associate assistants (these last two categories specifically reserved for non-European doctors).²² While associate assistants had almost the same level of pay as French assistants, FFIs and associate sessional doctors were, for their part, paid

21. Christian Chevandier, *L'hôpital dans la France du XX^e siècle* (Paris: Perrin, 2009).

22. They were created respectively in 1981 and 1987. The status of associate sessional doctor replaced that of foreign sessional doctor, which dated back to 1974.

much less than residents and French sessional doctors.²³ Further, assistants benefited from two-year employment contracts (renewable for a maximum of four years, which was extended to six years in 1995), while FFIs could only sign six-month contracts, and associate sessional doctors were paid by the session. The vast majority of doctors with non-European diplomas were employed in the latter two categories, which were the least well paid and most precarious. According to censuses conducted by the National Academy of Medicine and the Ministry of Health, this was the case for more than two-thirds of them in 1994–1995.

Hospitals had no trouble filling these positions. There were many candidates for these jobs because of a university cooperation policy that encouraged doctors from foreign countries to complete their training in France. Continuing an old tradition,²⁴ French diplomatic and university authorities were promoting international educational and scientific exchanges. For interested foreign states—mainly those from France’s former colonial empire—the aim was to enable their graduates to acquire specialized skills unavailable at home. Their students could, of course, study for French university diplomas (*Diplômes d’université*—DUs), but these diplomas were not approved by the state, and had titles that varied from one university to another. Thus in the view of foreign states’ university authorities, they did not offer sufficient guarantees for training. Moreover, after the reform of medical studies in 1982, their students were not allowed to take the competitive residency examination. It was therefore to improve the further training of their graduates in France that the directors of French-speaking medical schools in countries in the South set up specific courses in consultation with the Conference of Medical School Deans. Based on the model of the specialized studies diplomas (*diplômes d’études spécialisées*—DES) reserved for French residents, inter-university speciality diplomas (*diplômes interuniversitaires de spécialité*—DIS) were thus created in 1985.²⁵ Students from outside the EEC could enroll for these courses, which lasted three to four years, after obtaining an attestation of preparatory specialized studies; and later, as of 1991, after passing a competitive examination. In 1991, shorter courses of between six months and two years were introduced. As with DIS courses, it was expressly stated that these courses did not give the right to practice medicine in France. *This was in accordance with the wishes of the foreign*

23. In 1994, the remuneration of FFI doctors was less than one-third of that of first-year residents (who were themselves paid less than more senior residents), and three times less than that of an associate assistant. In 1994 again, sessions performed by associate sessional doctors in general hospitals were paid F 221, compared with 250 to 293 for French sessional doctors. There were similar discrepancies in the pay for shift duties.

24. George Weisz, *The Emergence of Modern Universities in France, 1863–1914* (Princeton, NJ: Princeton University Press, 1983).

25. At the request of the deans of certain medical schools in North Africa, a very selective competitive residency examination for foreigners was also introduced in 1987. Only seven to eight students passed each year until it amalgamated with DIS examinations in 2000.

states themselves, which, having provided initial training, wanted their doctors to bring their specialized French training home.

In 1992–1993, there were a total of 15,500 foreign students enrolled for postgraduate diplomas in French medical schools. They came mostly from countries in Mahgreb, the Near East, and Sub-Saharan Africa. Among these students, only the few hundred who had passed the competitive end-of-first-year examination were studying for the state diploma. The others were either enrolled in the approved courses reserved for them or the DUs.²⁶ Their numbers therefore exceeded the number of positions open to them in hospitals. Many were obliged to make do with unpaid residencies in hospitals.²⁷ The possibility of any paid hospital position, even poorly paid, was thus attractive to these doctors, who often were not from well-off families.²⁸ Due to poor career prospects in their home countries, some of which were also prone to political turmoil (for example, Algeria in the 1990s), many sought to extend their stay in France by finding employment in a hospital, including as care assistants and nurses.²⁹ Several thousands of these doctors, in the hope of one day obtaining full authorization to practice, successively enrolled for several diplomas and, having gained the confidence of their heads of department and colleagues, were able to settle down in France, start families, and acquire French nationality.³⁰

The growth in recruitment of doctors with non-European diplomas in public hospitals from the middle of the 1980s was therefore not due to any proactive policy. The authorities, having initially facilitated recruitment by creating special statuses for these doctors, rapidly sought to limit them. As of 1987, several circulars were published with guidelines for hiring FFIs and associate sessional doctors, making requirements stricter. In 1991, a decree, completed by an order the following year, forbade hospitals (as of January 1, 1994) from recruiting foreign FFIs not studying for state-approved diplomas.

However, the authorities were unable to enforce these measures. The primary aim of local hospital service managers was to ensure the operation of

26. There are no statistical data to suggest how these students were distributed between the two pending types of training. Our sources lead us to estimate that most enrollments were for the DU.

27. A 1992 ministerial circular stated that “students enrolled for AFS or AFSA [short courses] could be hired [as hospital trainees] as non-remunerated extra staff” (circular DGS/OD/DH n° 92-322, October 2, 1992). A 1990 survey, at the Pitié-Salpêtrière CHU (teaching hospital), revealed that, out of 400 foreign students working there, half were on unpaid internships. See Linda Denour and Rémi Junker, “Les médecins étrangers dans les hôpitaux français,” *Revue Européenne des Migrations Internationales* 11 (3) (1995).

28. Denour and Junker, “Les médecins étrangers.”

29. From 1975 onward, several circulars specified how doctors with non-European diplomas could be recruited as healthcare assistants and nurses. This was intended to enable them to access paid work while waiting for full authorization to practice.

30. In 1994, two-thirds of them had acquired French nationality. See Paul Malvy, “L’exercice en France des médecins étrangers (problèmes posés par l’application de la loi du 13 juillet 1972),” *Bulletin de l’Académie Nationale de Médecine*, 178 (7) (1994).

their services and maintain acceptable working conditions for their attending staff. The latter delegated many of the more unpleasant hospital tasks, such as nightshifts and emergency duties, to doctors with non-European diplomas. According to a survey conducted by the Ministry of Health in 1994–1995, these doctors completed an average of 6.1 nightshifts a month, compared with 3.8 for foreign doctors from within the European Community, who probably worked according to a system similar to that of French doctors.³¹ Thus, in view of their precarious situation and low income, the vast majority of doctors with non-European diplomas had to accept positions unfilled by residents and French doctors, and perform the tasks that the latter were more reluctant to do. This explains why, despite the status of FFI or associate sessional doctor, (calling for the latter to work “under the direct responsibility” of their head of department or one of his/her colleagues), doctors with non-European diplomas in fact had considerable autonomy in their work. This was recognized in an official report in 1997: “[These] doctors hold de facto clinical responsibilities that place them in a position equivalent to that of French doctors, particularly when performing the more demanding parts of these jobs—nightshifts and emergency duties.”³²

The Irruption of “Foreign Doctors” onto the Public Stage

At the end of the 1980s, the recruitment of doctors with non-EEC diplomas began to draw open criticism from within the medical profession primarily from the dominant sections of the profession. A union of self-employed surgeons, the National College of French Surgeons (*Collège national des chirurgiens français*), was the first to address the issue. In December 1988, it succeeded in having the National Academy of Medicine make a statement on the situation of French surgery, about the loss of prestige in the profession, both in the self-employed sector and in public hospitals.³³ The recruitment of doctors with non-EEC diplomas was presented as symptomatic of worsening practice conditions in hospitals and a loss of prestige of certain specialized areas, such as surgery.

Doctors who denounced such recruitment added concerns for public health, by throwing into doubt the competency of doctors with non-EEC diplomas. In its statement, the Academy expressed concerns that vacant positions in hospitals could be “filled, sometimes for a number of years, by foreign surgeons who were neither qualified, nor eligible for qualification in France.” In 1989, it was the turn of the CSMF and the National Association of Medical Students in France (*Association nationale des étudiants en médecine de France*) to defend the

31. Magali Coldefy, “7,500 médecins à diplôme non européen dans les hôpitaux français en 1995,” *Solidarité et Santé* 1 (1999).

32. Michel Amiel, *Commission P.A.C. (praticien adjoint contractuel)*, (report for the Secretary of State for Health, 1998, unpaginated).

33. André Sicard, “Sur la situation actuelle de la chirurgie française,” *Bulletin de l’Académie Nationale de Médecine*, 172 (9) (1988).

idea that “foreign, under-qualified, and underpaid labor should not be allowed to work in hospitals.”³⁴ For these organizations, however, the problem posed by recruiting doctors with non-European diplomas was viewed differently than by surgeons. The scale of recruitment was due to a large number of young French graduates no longer pursuing hospital careers, and choosing private practice instead. The lost prestige of hospital careers was therefore seen to increase competition in the self-employed sector and to be feeding a “glut” that the lowering of the *numerus clausus* of the late 1970s should have been limiting.

For their part, the public authorities began to look more closely at the question of doctors with non-EEC diplomas. As we have seen, measures applied from 1987 onward to limit recruitment of these doctors had no effect. Furthermore, these measures contradicted government policy relating to medical demographics since the late 1970s, and the government’s stated desire to control the development of health spending. In addition, criticism in the medical press concerning the recruitment of foreign doctors led to government fears of increased mediatization of the problem, which could create political difficulties. Doubts expressed over the competency of foreign doctors legally allowed to practice in public hospitals, and their working conditions, could bring criticism of the government’s public health policy and to “accusations of xenophobia.”³⁵ Lastly, the situation of these doctors was seen in its “human aspect.”³⁶ Their working conditions did not adequately reflect the importance of the hospital services they performed.

As soon as Simone Veil was named Minister of Social Affairs, Healthcare, and Urban Policy in March 1993, all these factors led her to address the question of doctors with non-European diplomas. However, the dual concern, to avoid measures that contradicted the stated objective of controlling health spending, and not to defy the will of the medical profession, resulted in a law that, contrary to its intended purpose, effectively made discrimination against these doctors even more evident.

The Failure of Widely Practiced Integration: The Law of February 4, 1995

The question of doctors with non-European diplomas was placed on the government’s agenda at a time of budgetary difficulties. The recession of 1993 led to a sharp increase in the public health insurance budget deficit (F 27.6 billion, compared with F 4.1 billion the previous year³⁷). Between May and August 1993, the government took numerous measures to reduce public spending on

34. *Le Médecin de France*, November 17, 1989.

35. Archives of the office of the Ministry of Social Affairs, memo dated September 8, 1993, CAC 19960368.

36. *Ibid.*

37. Bruno Palier, *Gouverner la sécurité sociale. Les réformes du système de protection sociale depuis 1945* (Paris: Presses universitaires de France, 2002).

health insurance. However, while it limited deficit growth, it did not manage to reduce it.

Given this context, the Ministry of Social Affairs considered that, while the situation of doctors from outside Europe should be improved, this should be done at limited cost to the public health insurance fund. The granting of full authorization to practice was excluded from the outset: "Such measures would have a non-negligible financial impact. Besides the risk of increasing the number of doctors able to set up in the self-employed sector, providing ordinary hospital status to medical staff, whose current incomes [. . .] are mediocre, would directly lead to an increase in hospital spending."³⁸

In December 1993, the Minister of Social Affairs therefore opted for the solution of creating a "body of integration," i.e. a specific status for doctors with non-European diplomas. Doctors holding this status would be recruited on a contractual basis and receive less pay than hospital practitioners. Furthermore, they would not be allowed to practice outside of hospitals. These terms were justified because access to this status would not be overly selective, to benefit the greatest number. The approach envisaged was thereby "widely practiced integration."³⁹ The Ministry of Social Affairs estimated that it could encompass 8,500 doctors.

However, when the draft bill was submitted to the French parliament in autumn 1994, it drew severe criticism from the medical profession. Arguing that doctors with non-European diplomas did not all have the required competencies, unions of hospital doctors and young doctors (residents and chief residents) demanded that, contrary to the original intention of the Ministry of Social Affairs, beneficiaries of the new status take highly selective tests. Moreover, the public authorities, joining in with self-employed practitioners' unions, then declared their determination to fight against the "medical glut," notably by reducing the *numerus clausus* to a very low level. In this context, offering stability to a large number of doctors with non-European diplomas was presented as being unfair to medical students who had failed the end-of-first-year competitive examinations.

These criticisms were picked up by the mass media. Coverage sometimes adopted an overtly xenophobic tone. "Foreign doctors," as they were called, were stigmatized *en masse*, due to their alleged incompetence and insufficient mastery of the French language. Several newspapers reported accounts of surgical procedures that went wrong and testimonies or suspicions of illegal trading

38. Memo from the DGS and the Population and Migration Department (*Direction des populations et migrations*), Autumn 1993, CAC 19960368.

39. Memo written by an employee of the French Hospitals Department, 1995, CAC 19960368.

of diplomas. Certain anecdotes were thus presented as emblematic of the “problem,” such as the story of “Hamid [. . .], house painter, [. . .], who managed to work as an FFI in a hospital in Oyonnax for five years, and [who] would still be working there if his spouse had not denounced him.”⁴⁰

The use of such xenophobic stereotypes was limited to newspapers with a conservative or far-right readership. They did not make their way into parliamentary debates. However, due to the opposition of several members of parliament in the majority party, who echoed the criticisms expressed by the medical profession, the government had to resort to the “blocked-vote” procedure to have the law adopted. The law was finally promulgated on February 4, 1995. It was then supplemented, in May 1995, by various decrees and orders that specified the status of contractual assistant practitioner (*praticien adjoint contractuel*—PAC), and defined the nature of the tests required to obtain it.

The provisions for PACs aligned with the government’s original intent. This included restricting PAC authorization to hospitals. It did not extend to private practice, which, according to the self-employed practitioners’ unions, was an overcrowded area. Further, authorization to practice was valid only for the duration of the PAC’s fixed-term contract (three years, renewable). Significantly, the law allowed PAC doctors a “partial and temporary” authorization to practice, registered under a “specific section” in the table of the *Ordre des médecins*. Finally, at the start of PACs’ careers, the pay was less than half that of attending hospital practitioners, and the salary progression throughout the career was particularly slow.

However, the tests to obtain PAC status, and the requirements to register for it, were far more selective than the government had wanted. According to a study conducted in 1995 by the public hospital system of Paris (*Assistance publique des hôpitaux de Paris*) among its personnel, “out of the 1,750 [doctors with non-European qualifications] identified in May, less than 30 percent fulfill a priori the conditions required to take the national aptitude tests.”⁴¹ In fact, barely 4,000 candidates passed the four test sessions organized between 1996 and 1999, compared to the target of 8,500 initially set by the Ministry of Social Affairs. In other words, more than half of the doctors with non-European diplomas, identified in hospitals when the law was promulgated, did not achieve PAC status.

This situation explains why hospitals continued to hire these doctors under preexisting status policies—even when they were not preparing for

40. *Le Figaro*, October 29, 1993. The case of Hamid (surname not mentioned) was raised for the first time by the far-right weekly newspaper *Minute* on September 29, 1993. It was brought up again, with a host of details, in an issue of *Le Point* on May 27, 1995.

41. *Le Monde*, October 26, 1995.

state-approved diplomas. This became illegal as of January 1, 1996, and thus would have allowed the public authorities to close down the services they provided. For staff at the Ministry of Health, the existence of many “small hospital facilities,” with their own surgical and emergency departments, were the “source of the evil.”⁴² The transformation of these unappealing (in the eyes of French doctors) hospitals, into “medico-social facilities,” i.e. long-stay establishments with limited medical services, was the only solution to end hiring doctors with non-European diplomas for public hospitals. However, while this was a solution backed by the dominant segments of the medical profession (Parisian teaching hospital doctors and surgeons in particular), the Ministry of Health was well aware that these “restructuring” methods would be met with significant political obstacles at local level. Unable therefore to apply these quick solutions to resolve recruitment problems, the authorities adopted the pragmatic approach of turning a blind eye to illegal recruitment.⁴³

The Turning Point of Regularization

Although it was presented by the authorities as a step forward for doctors with non-European diplomas, the February 1995 law and implementation of legislation drew much criticism. Starting in 1994, doctors from the less dominant areas of hospital medicine repeatedly spoke out, denouncing the accusations of incompetence expressed by prominent members of the medical profession regarding “foreign doctors.” The head of a Paris hospital’s psychiatric department wrote the following, concerning a report by the National Academy of Medicine: “Once again, a connection has been made between the numerous foreign doctors working in public hospitals and their lack of professional qualifications [. . .]. [Hospital doctors] witness their skills on a daily basis and, as is the case with all doctors, their possible shortcomings.”⁴⁴

In addition, the same doctors, who had demanded that doctors lacking European diplomas take rigorous examinations to continue practicing, also criticized, very early on, the PAC status. They saw that a category of practitioners barred from working outside of hospitals risked lowering the prestige of public hospitals. It could create the “impression that standards for hospitals are lower than for the self-employed sector.”⁴⁵ Organizations for young doctors also feared that creating PAC positions reduced their chances of being recruited as hospital practitioners (*praticiens hospitaliers*—PHs) in teaching hospitals. Faced with significant budget constraints, hospitals might be tempted to create PAC positions instead of the more costly PH positions. Representatives of young doctors,

42. In a memo from the Sub-Department of Health Professions, on June 24, 1993, CAC 19960368.

43. In 1997 and 1998, two circulars gave temporary permission for hospitals to employ doctors with non-European diplomas who were not studying towards a state-approved diploma.

44. Gilbert Ferrand, “Des boucs émissaires,” *Le Monde*, May 18, 1994.

45. According to Professor Alain Haertig, “La titularisation des médecins étrangers,” *Le Figaro*, January 5, 1995.

general hospital doctors, and teaching hospital doctors therefore demanded that doctors with non-European diplomas have full and equal rights to practice as doctors with French diplomas. They were to be allowed to compete for PH positions and work in the self-employed sector—but *under the condition of passing a rigorous exam*. Thus, the redefining of medical demographics by the mid-1990s favored change in this direction. The fear of a medical glut gave way to a fear of “shortages.” The *Ordre des médecins* and several unions of self-employed and hospital practitioners began to worry about an anticipated reduction in the number of doctors in the 2000s leading to an increase in their workload.⁴⁶

At the same time, doctors with non-European diplomas began to form organizations for themselves. The leaders of several that were founded publicly exposed the discrimination that they themselves and their colleagues had endured. In April 1995, they were quoted a number of times in *Le Monde*, as the newspaper denounced the discriminatory nature of the Law of February 4, 1995, and described the implementation of this legislation. In October 1995, for the very first time, the Committee for Doctors with Foreign Diplomas (*Comité des médecins à diplôme étranger*) and the Association of Associate Sessional Doctors (*Association des attachés associés*) organized two days of strikes. These organizations also attempted to bring legal action in order to remove the implementing regulations for the February 4, 1995 law—first with the French Council of State (*Conseil d’État*), and then, after the failure of the first attempt, with the European Court of Human Rights. Moreover, doctors with non-European diplomas received support from several humanitarian doctors’ associations and organizations defending human rights and foreigners’ rights. By highlighting the importance of services performed by doctors with non-European diplomas in public hospitals and the conditions under which they were employed, these organizations formed a powerful force for raising awareness of their cause with newspapers and public authorities. In February 1998, they created the “Commission for Equal Rights for All Doctors Practicing in France”. Their actions led to a symposium “for the equality of the practice of medicine in France”, at the French National Assembly in November 1998, with the explicit aim of raising awareness of the issue among members of parliament.

The legislative elections of 1997, which led to a surprise victory for left-wing parties, were a boost to putting the issue of doctors with non-European diplomas back on the government’s agenda. Indeed, the new government made fighting discrimination against foreigners a political priority.⁴⁷ A report from the High Council for Integration submitted to the prime minister in December

46. Marc-Olivier Déplaudé, “De l’erreur en politique. Le cas de la régulation démographique du corps médical en France (1980–2005),” in *Dynamiques de l’erreur*, eds. Christiane Chauviré, Albert Ogien and Louis Quéré (Paris: Éditions de l’EHESS [“Raisons pratiques 19”], 2009).

47. Didier Fassin, “L’invention française des discriminations,” *Revue Française de Science Politique* 52 (4) (2002).

1998, *Lutte contre les discriminations: faire respecter le principe d'égalité* (The Fight against Discrimination: Ensuring Respect for the Principle of Equality), was the first official report devoted entirely to this question.

For strategic reasons, organizations grouped together within the Commission for Equal Rights for All Doctors Practicing in France focused strongly on discrimination. Shortly following his nomination as Secretary of State for Health, Bernard Kouchner focused on the issue. In July 1997, he promulgated a decree that eased the conditions required for taking the PAC tests, according to the recommendations of a report ordered by the previous government. However, he sought a more wide-ranging response to the issue, including the granting of *full rights* to practice for a large proportion of doctors with non-European diplomas working in hospitals. For this to be politically acceptable, he needed to raise the *numerus clausus* for medical studies. It was essential that “foreign doctors” not appear to be taking positions usually reserved for “French doctors.” With the backing of the prime minister, he succeeded in having the *numerus clausus* raised from 3,583 to 3,700 in December 1998, going against the opinions of the Social Security Department, the Budget Department, and public health insurance management, which were still concerned about containing health spending growth. Even though this was only a slight rise, it signaled “a break from the previous policy,”⁴⁸ which consisted of reducing and keeping the *numerus clausus* at a very low level. The *numerus clausus* continued to be raised during subsequent years, moving from 3,700 in 1999 to 7,000 in 2006.

This policy shift on medical demographics facilitated the adoption of significant regularization measures in December 1998. First, the quota of individual authorizations to practice was increased sharply. Standing at only 75 in 1997, it was raised to 400 in December 1998, then lowered to 300 the following year. Moreover, in June 1999 a decree authorized PAC doctors to take the hospital practitioner (PH) competitive examination, and removed the citizenship condition formerly required for this exam. PAC doctors who passed the PH competitive examination thereby achieved full authorization to practice medicine. In 2000, 872 doctors passed the examination.

However, the most important reform was about authorization, which underwent significant change with the law of July 27, 1999. Firstly, PAC testing, which should have ended in 1999, was extended by two years. Secondly, PAC doctors were now registered in the general table (i.e. no longer in a special section) of the *Ordre des médecins*. Their status improved. After practicing for three years as PACs, or working in a hospital for six years, they would now automatically be granted full authorization to practice—with *no quota*. Thirdly, doctors who had passed the national aptitude tests introduced by the Law of July 13, 1972, but had

48. Interview with former staff member of the office of the Secretary of State for Health, March 9, 2006.

not received full authorization to practice or passed the PAC competitive examination, could now obtain—*again with no quota*—full authorization to practice if they had worked in a hospital for at least six years. Lastly, a commission known as the “10-year” commission was established to examine, on a case-by-case basis, the files of doctors who had practiced for at least 10 years in French hospitals but failed the aptitude tests introduced by the Law of July 13, 1972.

In total, according to a memo from the Department of Hospitalization and Healthcare Organization (*Direction de l’hospitalisation et de l’organisation des soins*—DHOS) in 2006, 4,236 PAC doctors obtained full authorization to practice; approximately 2,600 were granted, beyond the quota, to doctors who had passed the aptitude tests, and 153 others were granted by the 10-year commission. In total, therefore, nearly 8,000 doctors with non-European diplomas obtained full rights to practice in France over the space of a few years (four times as many as between 1975 and 1998).

However, while it regularized the situation of doctors who were *already* working in French hospitals, the Law of July 27, 1999, also sought to reorganize and limit future recruitment of doctors with non-European diplomas. It therefore provided for the introduction of a new procedure for the granting of rights to practice, while forbidding, like the February 1995 law, the recruitment by hospitals of doctors not studying for a state-approved diploma, except for refugee, stateless, or asylum-seeking doctors. However, due to delays in introducing this new procedure and its later inability to satisfy the needs of hospitals,⁴⁹ the hospitals continued to recruit doctors with non-European diplomas (using precarious status criteria) even when they were not studying for a state-approved diploma. Six years after the promulgation of the July 1999 law, a survey conducted by the DHOS, to which 76 percent of the establishments questioned responded, identified more than 6,700 doctors employed under the status of FFI, associate sessional doctor, or associate assistant.⁵⁰ The mid-2000s, therefore saw a return to the situation that had existed before the February 1995 law, which gave rise to further mobilization and new regularization measures from the public authorities.

Conclusion

The legal barriers established between the end of the nineteenth century and the 1930s to dissuade foreigners from practicing medicine in France were subjected to significant adjustments during the postwar period. The requirement

49. The new authorization procedure was not introduced until 2004. Candidates for full authorization must take a competitive examination for a predefined number of places for each specialty, and then work for a minimum of three years in a hospital before being put forward again for assessment. In total, approximately 200 hundred doctors have been received in hospitals each year since 2005.

50. Cour des comptes, *Les personnels des établissements publics de santé* (Paris, 2006).

for French citizenship was attenuated to a certain degree by the signature of numerous agreements with foreign states. The diploma requirement, on the other hand, was maintained far more strictly. From 1977 onward, it created competition between doctors trained in EEC member states, with rights matching doctors holding France's state diploma, and doctors holding non-European diplomas, who needed prior authorization from the Ministry of Health (from 1975 onward, granted very sparingly).

Nevertheless, the regulatory framework left hospitals able to recruit doctors who did not satisfy the general conditions for practicing medicine in order to fill certain types of positions. Some of these were even earmarked for them, such as associate sessional doctor and associate assistant. From the 1980s, several thousand doctors with non-European diplomas were thereby hired in public hospitals, working in demanding, poorly paid positions. This recruitment policy can be explained, as we have seen, by the impact on hospitals of the 1982 medical studies reform; by government policy on medical demographics, emphasizing internal disparities in the medical profession; and by the presence in France of a significant stream of doctors from Mahgreb, the Near East, and Sub-Saharan Africa, who came to France for additional training.

After the late 1980s, public policy on doctors without EEC diplomas can be understood as compromises to meet diverse, and at times contradictory concerns: guaranteed competency of doctors; fair treatment of medical students who failed the end-of-first-year competitive examinations; contained health spending; returning doctors who had come to France to acquire additional training to their country of origin; viable status for doctors who succeeded in prolonging their stay in France. The separate interests were championed by actors from the politico-administrative sphere, the medical profession, the voluntary sector, media, and foreign nations. Policy decisions made at government level did not simply reflect consensus within the French medical profession, but came out of the struggles between actors representing different interests. Their outcome depended on an unequal balance of power among the various proponents, and on the opportunities offered by the social world to support their positions.

To consider xenophobia to be the exclusive cause of the situation of doctors with non-European diplomas employed in public hospitals, and the prevailing policies up to and including the 1990s, would therefore be simplistic. Xenophobic statements were indeed made publicly during the debate over these doctors in the 1990s and even after.⁵¹ However, public policy was not exclusively or

51. As in 2006, when the president of the National Union of Gynecologists and Obstetricians declared to a journalist from *Agence France Presse* that if patients did not agree to paying additional fees for certain specialized ambulatory care treatments, "then they should go to a hospital to get treatment from a practitioner with a foreign diploma" (quoted in *Le Monde*, September 3–4, 2006).

even primarily xenophobic—far from it. Attributing xenophobia to political, administrative, political, and intellectual elites, and accepting that an “ideological osmosis”⁵² exists among them, runs the risk of turning the notion of xenophobia into an epistemological obstacle. This prevents us from seeing *all* of the political and social factors at work in the creation and perpetuation of discrimination affecting foreigners.

Today, granting full authorization to practice to doctors with non-European diplomas continues to follow the quota system. Should this be seen as a remnant of the xenophobic movements at the end of the nineteenth century and 1930s? Medical practice in France has changed profoundly since then. In particular, two major changes should be taken into account. One is mandatory public health insurance (1945). This improved the financial situation of the vast majority of doctors and eased competition within the profession, and also made broad healthcare spending a government concern. The other is the *numerus clausus* system for medical studies (1971). For French doctors, the granting full authorization to practice to doctors who had not passed the competitive examination at the end of the first year of French medical studies raised issues of fairness. Control of health spending and the *numerus clausus* were intimately linked. Rather than call into question the right of all doctors with French nationality and the required diplomas to be covered by the public health insurance fund (so that their fees and prescriptions were covered by Social Security) the government authorities preferred, with the support of certain segments of the medical profession, to limit the number of doctors trained in France via a *numerus clausus* set at the start of their studies. *For the same reasons*, this would inevitably lead to a quota for doctors trained abroad if too many of them would become candidates to practice medicine in France. This is precisely what was feared about doctors from outside Europe. However, the demands of fairness and the need to control public spending can conflict with issues of human rights. Conflicting demands were difficult to reconcile, including some that were based on strong moral arguments, which explains why the issue of “foreign doctors” gave rise to an animated public debate in which xenophobia was not absent.

52. Jérôme Valluy, “Du retournement de l’asile (1948–2008) à la xénophobie de gouvernement: Construction d’un objet d’étude,” *Culture & Conflits* 69 (2008).

List of Main Acronyms and Abbreviations

IA	Intermediate archives
CAC	<i>Centre des archives contemporaines</i> [Center for Contemporary Archives]
CES	<i>Certificat d'études spéciales</i> [specialized study certificate]
CHU	<i>Centre hospitalier et universitaire</i> [teaching hospital]
CSMF	<i>Confédération des syndicats médicaux français</i> [Confederation of French Physicians Unions]
DES	<i>Diplôme d'études spécialisées</i> [specialized studies diploma]
DGS	<i>Direction générale de la santé</i> [General Health Service Department]
DHOS	<i>Direction de l'Hospitalisation et de l'Organisation des Soins</i> [Department of Hospitalization and Healthcare Organization]
DIS	<i>Diplôme interuniversitaire de spécialité</i> [inter-university specialty diploma]
DU	<i>Diplôme d'université</i> [French university diploma]
FFI	<i>Faisant fonction d'interne</i> [a person who does the job of a resident, without holding the title of resident and with a lower pay]
PAC	<i>Praticien adjoint contractuel</i> [contractual assisting practitioner]
PH	<i>Praticien hospitalier</i> [hospital physician]

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