

Immigrant Doctors and the Transnational Roots of Canadian Medicare

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IN A RECENT FRONT-PAGE STORY published by the *Telegram* in St. John's, Newfoundland, journalist Peter Jackson observed that only one 2021 Memorial University of Newfoundland medical school graduate has agreed to establish a practice in the province. Jackson states that this news comes at a time when "several existing family physicians" are reducing their practices or are retiring all together.¹ According to Jackson, the lack of new doctors, and the retirement of the older ones, are adding to the province's impending doctor shortage. During a recent visit to St. John's, federal Immigration Minister Marco Mendicino stated "One of the ways that we can provide reinforcements to the front lines of the health care sector is through immigration."² Mendicino's comment reflects the current federal government's recognition of a much publicized doctor shortage, and that immigration may provide a solution.³ But while journalists are helping to raise awareness of this issue, the historic root causes are left unexamined.

Fortunately, two of Canada's most accomplished historians of medicine, Sasha Mullally of the University of New Brunswick and David Wright of McGill University, have published *Foreign Practices: Immigrant Doctors and the History of Canadian Medicare*. The central purpose of their text is to examine the immigration of foreign-trained doctors to Canada following the Second World War and the vital role they played in the delivery of health services during the transition to Medicare during the late 1960s and early 1970s.⁴ To frame this narrative, Mullally and Wright focus on the years between 1957

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- 1 Peter Jackson, "Newfoundland's doctor shortage: the international factor," *Telegram* (St. John's), 15 August 2021, <https://www.saltwire.com/atlantic-canada/news/newfoundlands-doctor-shortage-the-international-factor-100623843/>.
 - 2 Jackson, "Doctor Shortage."
 - 3 "'Clearly, We Have Some Unhappy Doctors,' says acting CEO of Health PEI," *CBC News*, 12 May 2021, <https://www.cbc.ca/news/canada/prince-edward-island/pei-gardam-compass-health-pe-i-doctor-shortage-1.6024260>; Jagdeesh Mann, "Even During a Pandemic, Immigrant Doctors Struggle to Find Work," *Walrus*, 5 May 2021, <https://thewalrus.ca/even-during-a-pandemic-immigrant-doctors-struggle-to-find-work/>; Nicholas Keung, "Foreign Doctors Petition for Ability to Practice While They Wait," *Toronto Star*, 13 September 2010.
 - 4 Sasha Mullally and David Wright, *Foreign Practices: Immigrant Doctors and the History of Canadian Medicare* (Montreal and Kingston: McGill-Queen's University Press, 2020), 10.

and 1984 as immigrant physicians established themselves throughout Canada. Mullally and Wright primarily argue, as a result of their study of the links between immigration and health care, that universal health insurance in Canada was able to survive because of the influx of foreign-trained doctors, who bolstered the nation's ability to deliver health services to an expanding population. Without immigrant physicians, Canada would have been unable to provide the number of doctors needed to make Medicare a success.

By examining the statistics, the authors show that in the two-and-a-half decades after the passage of the 1957 Hospitalization Insurance and Diagnostic Services Act (HIDS Act) more than 15,000 foreign-trained doctors arrived in Canada. With this figure in mind, one of the authors' goals is to observe the routes taken by international medical graduates as they migrated to and within the country.⁵ Because it concentrates mostly on Canada, *Foreign Practices* is also a national history as certain provinces and regions were affected by physician immigration more than others. According to Mullally and Wright, their text focuses, in particular, on the disparities that existed in the delivery of health services in "marginalized, rural, and remote communities," the private or incorporated group practices, and the community health centres that were popular throughout these decades, as well as the growth of new Canadian medical schools. In analyzing these facets of health service delivery, the authors describe how immigrant physicians "fit into and exerted an influence on the economic and corporate structures" of Canadian health care. For example, as Mullally and Wright explain, the influx of foreign-trained doctors influenced the upper echelons of Canadian health care's corporate structure as "a notable few of this generation of doctors" became "presidents of medical associations, heads of clinical departments, and deans of medical schools." Yet, further down the corporate stratum, in rural or remote resource communities, "physicians' health care practices" were restructured from "hierarchical to collaborative group practices" as a more democratic and equal working environment between physicians ensured higher rates of doctor retention in these difficult-to-service areas.⁶ Another contribution Mullally and Wright make is their analysis of the complex moral dilemmas surrounding the "brain drain," which saw foreign-trained physicians leave developing nations in favour of opportunities in the developed world.⁷ And Mullally and Wright also present the problem of doctor

5 Mullally and Wright, *Foreign Practices*, 11.

6 Mullally and Wright, *Foreign Practices*, 11, 256, 220-1.

7 Mullally and Wright, *Foreign Practices*, 12.

maldistribution that the Canadian federal and provincial governments tried to solve from time to time; this was done by forcing physicians to practise in underserved areas. As the authors argue, however, following the passage of the Canadian Charter of Rights and Freedoms, government could do little to prevent doctors from choosing where to live and practise.⁸

The key historiographical intervention Mullally and Wright make is that they reveal the ways in which the immigration of foreign-trained doctors influenced the “delivery of health care in Canada” between the late 1950s and the mid-1980s. As they note, few scholars have assessed the links between Medicare and immigration, with most studies focusing on policy history and the enactment of Medicare.⁹ Despite Mullally and Wright asserting that policy histories have been privileged over other narratives, scholars such as Gregory Marchildon argue that historians generally “have paid little attention to the history of Medicare” because of the profession’s limited interest in political history.¹⁰ Historian Heather MacDougall supports Marchildon’s claim, and suggests that scholars must “broaden the scope” of analysis on Medicare by exploring aspects of the social program’s history that have not yet been studied.¹¹ Mullally and Wright’s work on the immigration and distribution of physicians throughout Canada fits accordingly within a growing historiography that explores the provision of health care services nationally, including Indigenous and mental health care as well as various provincial narratives.¹² The text

8 Mullally and Wright, *Foreign Practices*, 251.

9 Mullally and Wright, *Foreign Practices*, 10, 7–8. For early examples of texts focusing on the development of Canadian health policy and Medicare, see Malcolm G. Taylor, “The Canadian Health System in Transition,” *Journal of Public Health Policy* 2, no. 2 (June 1981): 177–87; Taylor, *Health Insurance and Canadian Public Policy*, 3rd ed. (Montreal and Kingston: McGill–Queen’s University Press, 2009); Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions That Created The Canadian Health Insurance System* (Montreal and Kingston: McGill–Queen’s University Press, 1978); David C. Naylor, ed., *Canadian Health Care and the State: A Century of Evolution* (Montreal and Kingston: McGill–Queen’s University Press, 1986); and Naylor, *Private Practice, Public Payment: Canadian Medicine and the Politics of Health Insurance, 1911–1966* (Montreal and Kingston: McGill–Queen’s University Press, 1986).

10 Gregory P. Marchildon, *Making Medicare: New Perspectives on the History of Medicare in Canada* (Toronto: University of Toronto Press, 2012), 4.

11 Heather MacDougall, “Shifting Focus: Medicare, Canadian Historians, and New Research Directions,” *Canadian Bulletin of Medical History* 26, no. 2 (Winter 2009): 548, 551.

12 For examples of recent scholarly works that explore new aspects within the history of Canadian Medicare, especially Indigenous health care, mental health care, and provincial narratives, see Catherine Carstairs and Ian Mosby, “Colonial Extractions: Oral Health Care and Indigenous Peoples in Canada, 1945–79,” *Canadian Historical Review* 101, no. 2 (June 2020): 192–216; Erika Dyck, “Bitter Pills: The Impact of Medicare on Mental Health,” *Health Economics, Policy and Law* 13 (July 2018): 263–79; Eshyllt Jones, “Health and Nation Through

therefore serves as an essential addition to the historiography because their transnational approach underscores that doctor migration took place amid and across distinct nations and regions, and that immigration was critical in making Canadian Medicare a success.

Having been influenced by earlier histories on Medicare policy, as well as labour, migration, social, and oral history, Mullally and Wright assert that they use a “mixed methodology” to examine Canadian political institutions, legislative processes, and professional medical hierarchies that exerted influence on foreign-trained doctors who migrated to and practised within the country. Simultaneously, these physicians exercised their own agency against professional and political pressures since they often re-migrated to more desirable locations within Canada. As a result, Mullally and Wright’s work adds Canadian perspective to an interconnected transnational history.¹³

Mullally and Wright draw upon secondary sources ranging from conventional and revisionist institutional histories of medical schools, hospitals, and physicians to national and transnational medical histories written by scholars such as Naylor, Duffin, Jones, and Weisz.¹⁴ Mullally

a Transnational Lens: Radical Doctors and the History of Medicare in Saskatchewan,” in *Within and Without the Nation: Canadian History as Transnational History*, ed. Karen Dubinsky, Adele Perry, and Henry Yu (Toronto: University of Toronto Press, 2015), 293–310; Maureen K. Lux, *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s* (Toronto: University of Toronto Press, 2016); and Gregory P. Marchildon and Nicole O’Byrne, “From Bennett Care to Medicare: The Morphing of Medical Care Insurance in British Columbia,” in *Making Medicare: New Perspectives on the History of Medicare in Canada*, ed. Gregory P. Marchildon (Toronto: University of Toronto Press, 2012), 207–8.

13 Mullally and Wright, *Foreign Practices*, 8.

14 For examples of histories of Canadian medical schools, hospitals, physicians, and Medicare, see Naylor, *Canadian Health Care and the State*; Annmarie Adams, *Medicine by Design: The Architect and the Modern Hospital, 1893–1943* (Minneapolis: University of Minnesota Press, 2008); J.T.H. Connor, *Doing Good: The Life of Toronto’s General Hospital* (Toronto: University of Toronto Press, 2000); Martin Robert, “La Fabrique du corps médical : dissections humaines et formation médicale dans le Québec du XIXe siècle” (PhD diss., Université du Québec à Montréal, 2019); and Terrie Romano, “Professional Identity and the Nineteenth-Century Ontario Medical Profession,” *Histoire Sociale / Social History* 28 (May 1995): 77–98. For insight on Canadian Medicare’s American and international influences, see J.T.H. Connor, “One Simply Doesn’t Arbitrate Authorship of Thought: Socialized Medicine, Medical McCarthyism, and the Publishing of *Rural Health and Medical Care* (1948),” *Journal of the History of Medicine and Allied Sciences* 72, no. 3 (April 2017): 245–71 and Jacalyn Duffin, “The Guru and the Godfather: Henry Sigerist, Hugh MacLean, and the Politics of Health Care Reform in 1940s Canada,” *Canadian Bulletin of Medical History* 9, no. 2 (Fall 1992): 191–218. For other works on the transnational migration of physicians to Canada as well as the circulation of socialized medical ideas and policies into Canada, see Esyllt Jones, *Radical Medicine: The International Origins of Socialized Health Care in Canada* (Winnipeg: ARP Books, 2019) and George Weisz, “The Geographical Origins and Destinations of Medical Graduates in Quebec, 1834–1939,” *Histoire Sociale / Social History* 19, no. 37 (May 1986): 93–119.

and Wright argue, regarding the transnational literature in particular, that, while other scholars have analyzed Canadian Medicare as it was shaped by international influences, their own work adds to this scholarship by situating the “evolution of universal health insurance in Canada” within the complicated post-war context of globalization.¹⁵ They also integrate sources on economics, immigration, culture, and Canadian health policy, with each supporting their efforts to provide a broadly contextualized narrative of transnational physician migration and its effects on Canadian health care.¹⁶ One notable example is health economist Oscar Gish’s 1971 book *Doctor Migration and World Health*.¹⁷ Mullally and Wright use Gish’s work to help explain that physician migration may have benefited developed countries such as Canada, while doctor out-migration had detrimental repercussions on developing nations.¹⁸ Additionally, primary sources cited throughout the text include the Royal Commission on Health Services, provincial commissions of inquiry, various pieces of government legislation, and numerous studies on physician immigration as well as the *Canadian Medical Association Journal* and provincial medical association publications.¹⁹ The authors show ingenuity in their use of primary sources such as the Canadian Medical Association’s (CMA) annual *Canadian Medical Directory* (CMD) and the federal Department

15 Mullally and Wright, *Foreign Practices*, 12.

16 For examples of texts cited by Mullally and Wright on economics, see Lawrence Robert Aronson, *American National Security and Economic Relations with Canada, 1945-1954* (Westport and London: Praeger, 1997) and Janine Brodie, *The Political Economy of Canadian Regionalism* (Toronto: Harcourt Brace Jovanovich Canada, 1990). For works on immigration, see Lisa Chilton, *Receiving Canada’s Immigrants: The Work of the State before 1930* (Ottawa: Canadian Historical Association, 2016); Alan G. Green, *Immigration and the Postwar Canadian Economy* (Toronto: Macmillan of Canada, 1976); and Harold Troper, “Canada’s Immigration Policy Since 1945,” *International Journal* 48, no. 2 (Spring 1993): 255-81. For an example of a text on culture and migration, see Dirk Hoerder, *Cultures in Contact, World Migrations in the Second Millennium* (Durham, NC: Duke University Press, 2002). And for works on Canadian health policy, see Antonia Maioni, *Health Care in Canada* (Toronto: Oxford University Press, 2015); Maioni, *Parting at the Crossroads: The Emergence of Health Insurance in the United States and Canada* (Princeton, NJ: Princeton University Press, 1998); Gerard Boychuk, *National Health Insurance in the United States and Canada: Race, Territory, and the Roots of Difference* (Washington: Georgetown University Press, 2008); and Alvin Finkel, “Why Canada has a Universal Medical Insurance Programme and the United States Does Not: Accounting for Historical Differences in American and Canadian Social Policies,” in *Locating Health: Historical and Anthropological Investigations of Place and Health*, ed. Erika Dyck and Christopher Fletcher (London: Pickering and Chatto, 2010), 71-88.

17 Oscar Gish, *Doctor Migration and World Health: The Impact of the International Demand for Doctors on Health Services in Developing Countries* (London: Bell, 1971).

18 Mullally and Wright, *Foreign Practices*, 157-60.

19 Mullally and Wright, *Foreign Practices*, 10-6, 268-70.

of Immigration and Citizenship annual returns.²⁰ Mullally and Wright utilize these sources to determine when physicians arrived in Canada and where they came from. Other sources used by Mullally and Wright include doctors' published memoirs, "reminiscences," and oral history interviews that were conducted by the authors or were obtained through institutions such as Pier 21 in Halifax. Though these sources are "qualitatively different," the authors insist that both written and oral accounts help better illustrate the journeys made by immigrant doctors to and within Canada while they also humanize the life stories of physicians during their transnational migrations.²¹ The authors make judicious use of their evidence, and each main argument is well supported by their sources. In Chapter Five, for instance, Mullally and Wright explore the routes taken by physicians who fled to Canada from Czechoslovakia, Egypt, Taiwan, and Pakistan. Mirko and Vlasta Havlas, a married couple of physicians from Czechoslovakia, is but one example of this migration. Mullally and Wright use obituaries to illustrate their journey to Canada following the Soviet invasion of Prague in 1968, which triggered a wave of emigration from the country. Mullally and Wright then expand their scope by citing secondary sources describing the total number of Czechoslovakian immigrants who came to Canada in 1968 as numbering 11,000. By using the *CMD* the authors found that 285 physicians had been part of this wave of immigration and they demonstrate that Czech and Slovak physicians ended up practicing across Canada, with many residing in rural Prairie and Maritime communities by 1976. This medical diaspora of many physicians helped to support Medicare in its early years by broadening access to health services in rural areas.²²

The text's narrative is roughly chronological and moves between micro and macro analyses, beginning each chapter with an illustrative vignette of a doctor's life story. Chapter One, for instance, examines Arthur Leatherbarrow, an Irish doctor who immigrated to Canada after graduating from medical school in 1916. Mullally and Wright use his story to show that roughly 300 to 400 Irish- and British-trained physicians came annually to Canada in the first decades of the 20th century. By the late 1940s, however, Canada was facing multiple crises in health care. Rural regions had limited access to health services. Medical schools were too few and could not graduate

20 The CMA's *Canadian Medical Directory* serves as a census for all licenced physicians in Canada.

21 Mullally and Wright, *Foreign Practices*, 16, 8–9, 17.

22 Mullally and Wright, *Foreign Practices*, 122–8.

enough physicians to fill the nation's needs. To make matters worse, many of the doctors who did graduate often moved to the United States for better professional opportunities. For those who remained, they preferred to practise in urban areas closer to medical schools and hospitals. Then in 1948, the federal government issued health grants that expanded hospital services and, as a result, patient capacities surged during the 1950s. The Canadian healthcare system was stretched thin, and hospital administrators began arguing for changes to the nation's immigration policy so foreign-trained doctors could be brought in.²³

Mullally and Wright examine the impact in Canada of changes to Britain's health care system after the National Health Service (NHS) was created in July 1948. Once the NHS was established, the demand on existing medical services intensified. To alleviate pressure, administrators within the NHS recruited doctors from across the Commonwealth. Yet, in the new organizational structures of NHS, young physicians found it difficult to advance professionally and many stagnated in the same position for years. Canada then became a desirable alternative for those doctors because the country shared a common culture with Britain, it allowed for greater geographic mobility, and it lacked the same professional inertia.²⁴

In 1957, Prime Minister John Diefenbaker reintroduced a bill that became the Hospital Insurance and Diagnostic Services or HIDS Act. This ensured that the federal government would reimburse 50 per cent of the provinces' spending on acute hospital care and diagnostic services. The funding provided by HIDS guaranteed that citizens of all provinces were entitled to free inpatient and outpatient services, though the "actual funding formula" was to be far more complex.²⁵

Mullally and Wright show that as this new scheme became popular the demand for health services exploded, and this resulted in the need for more physicians. In 1961, the Royal Commission on Health Services was tasked with investigating the state of Canada's health care facilities and their needs. One of its research studies, focused on "Medical Manpower," determined that Canada needed immigrant doctors because of the increased demand for health services. Lester B. Pearson's government, based on the commission's recommendations,

23 Mullally and Wright, *Foreign Practices*, 48.

24 Mullally and Wright, *Foreign Practices*, 52, 54, 59, 63. The NHS is the United Kingdom's version of publicly funded healthcare.

25 Mullally and Wright, *Foreign Practices*, 72-5.

passed the Medical Care Act of 1966, which formally launched universal health insurance across Canada. The authors demonstrate that the passage of the Medical Care Act further exacerbated the nation's doctor shortage as the demand on health services increased in response to the act. One part of the solution was to create new medical schools, but the commission estimated it would be ten years before the country could produce enough of its own physicians. As Mullally and Wright assert, the only other option was to recruit foreign-trained doctors.²⁶

Another of the book's foremost contributions is its argument that the success of Medicare depended upon immigration reform.²⁷ Mullally and Wright highlight specific pieces of immigration legislation, such as the Fairclough Directive – a 1962 order-in-council that ensured Canada would no longer discriminate against immigrants based on their race, colour, or nationality. Crucially, in 1967, the Immigration Act instituted a points system that scored candidates based on their level of education, occupational demand, spoken languages, and willingness to settle in rural areas. Given the need for physicians, doctors often received top scores and were allowed entry at higher rates. Mullally and Wright use the *CMD* to provide evidence of the resulting influx, showing that while in 1961 there were 3,756 immigrant physicians practising in Canada by 1976 that number had climbed to 10,732 or roughly 31 per cent of all licenced physicians in the country. The authors also assert that many foreign-trained doctors were propelled toward Canada by political strife in their home countries, such as Egypt, Taiwan, Pakistan, India, South Africa, and Haiti. The authors, remarkably, also use these statistics to prove that 80 per cent of these physicians stayed in Canada, which offers a corrective to contemporary commentary that sometimes imply that foreign-trained doctors used the country as a spring board to access the US.²⁸

Another major contribution made by the authors is their analysis of the "Brain Drain" – a term describing the emigration of physicians and other highly skilled workers seeking career prospects and a better quality of life in another region or country.²⁹ While Canada experienced a drain of physicians to the US, Mullally and Wright carefully evaluate the moral quandaries associated with developed nations recruiting physicians whose own countries suffered

26 Mullally and Wright, *Foreign Practices*, 83–8, 91, 96.

27 Mullally and Wright, *Foreign Practices*, 96.

28 Mullally and Wright, *Foreign Practices*, 98, 102–3, 126, 128, 160, 128–49.

29 Mullally and Wright, *Foreign Practices*, 151.

because of physician out-migration. As the authors note, by the late 1960s reporters, politicians, the World Health Organization, and health economists all recognized the negative effects this brain drain was having on developing nations. Mullally and Wright emphasize, however, that the freedom of personal choice for physicians to live and work in a country of their choosing played a pivotal role in determining doctors' migration patterns. The authors also explore the difficult moral problem that physician migration presented, as health economists such as Alfonso Mejia argue that to prevent or prohibit a doctor from being able to make the personal decision to move elsewhere for work is itself unethical.³⁰

After observing physician migration on a global scale, Mullally and Wright turn back towards Canada and its rural regions where foreign-trained doctors were needed most. They argue that, due to Canada's size and regional diversity, health care bureaucrats and government officials found the planning and distribution of health services to be an enormous challenge. The authors point to a report submitted by the Ontario Medical Association to the Royal Commission on Health Services (1961-1964), which demonstrated that physicians aggregated in urban and suburban settings because of those areas having superior educational, recreational, and hospital facilities. Moreover, the report showed that rural practices left physicians with large caseloads and little time off. There simply were not enough incentives for doctors to practise rurally.³¹

Mullally and Wright examine the measures used to entice physicians into rural areas as communities were urged to create modern hospital clinics and while provincial and federal governments amended payment schemes to make rural practice more lucrative than urban. Despite these efforts, though, poorer provinces and rural regions struggled to retain physicians. Yet, as Mullally and Wright explain, since the late 1970s, Canadians have "conflated access with supply" in that the maldistribution of physicians between urban and rural areas is misunderstood as a shortage.³² In other words, people in rural regions struggle to access medical services, while they remain abundant in urban areas.

Although most physicians historically have been attracted to urban practices, Mullally and Wright outline some of the pathways taken by immigrant doctors who were pulled toward industrial and remote northern

30 Mullally and Wright, *Foreign Practices*, 153-60, 151-3, 174.

31 Mullally and Wright, *Foreign Practices*, 180, 184-5.

32 Mullally and Wright, *Foreign Practices*, 197, 198.

towns. In these communities, group practices established by older physicians, or certain public groups or unions funding a community health centre, regularly attracted new physicians. Foreign-trained doctors were ideal recruits in these settings as Canadian-born physicians often moved on after short periods, meaning positions were always available. Senior partners could also help accelerate the licensing process, which made these positions even more attractive. Another advantage was that immigrant doctors could gain wealth and experience without spending money to establish their own offices or clinics. Mullally and Wright thus demonstrate that Medicare would have been jeopardized had it not been for immigrant doctors providing services in rural, industrial, and northern resource towns.³³ After Medicare came into place, the formerly hierarchical structures of group practices became more democratized, and this enticed some foreign-trained physicians to stay in rural communities.

By the mid-1970s, the years of encouraging physicians to emigrate had come to an end. Most provincial ministers of health agreed that Canada had enough doctors. The real problem had become maldistribution, not undersupply. Beginning in 1973 the global oil crisis led to a Canadian recession, which reduced public support for immigration. In 1974 provincial ministers of health agreed that physicians should no longer be on the list of occupations preferred for immigration, and the CMA argued Canadian medical schools could now supply the entire country with new physicians. At the same time, federal and provincial ministers of health decided the interprovincial migration of physicians to urban areas had to be curtailed. By 1975 the then-minister of immigration and manpower, Robert Andras, initiated the Canadian Immigration and Population Study, which aimed to make recommendations for immigration reform. The results of this study influenced the Immigration Act, 1976, which made Canada's "humanitarian obligations" the primary goal when accepting immigrants. Mullally and Wright demonstrate that these factors led to the precipitous decline of foreign-trained doctors entering Canada, especially after the passage of the Canada Health Act in 1984, as they found it increasingly difficult to obtain a licence. By enshrining accessibility to care within the act, the federal government tried to ensure that no matter their location, patients would always have access to health services. Yet, in trying to control where physicians could migrate within the nation, the government ran up against the Charter of Rights and Freedoms, which deemed that no

33 Mullally and Wright, *Foreign Practices*, 200-2, 203, 209, 221-2.

government could force doctors into “underserviced” areas. This meant physician maldistribution would continue, but space was now created for new solutions such as incentivizing more women medical graduates and the increased use of midwives, nurse-practitioners, and physician assistants.³⁴

Though the book is an outstanding work of scholarship, readers looking for a behaviourist approach examining immigrant physicians therapeutic decision-making processes, or their medical thoughts and writings, will not find much here.³⁵ We essentially learn little about the medical practices of these doctors and the challenges they faced in Canada. And while Mullally and Wright do note the rewarding relationships some physicians developed in communities,³⁶ they opted not to probe patient perspectives and their experiences with foreign-trained doctors. Another critique is that Mullally and Wright do not address the role played by immigrant physicians in Indigenous communities even though scholars such as Maureen Lux have noted their employment within the Indian Health Service.³⁷ These are minor criticisms, though, since neither of these topics were prioritized by the authors. Such comments come as lingering curiosities that remain after reading the book. Hopefully, scholars in the future will conduct an assessment of the day-to-day practices of immigrant physicians or their work with Indigenous communities.

All in all, this insightful book is suitable for undergraduates, especially students in upper-level seminars wanting to learn about Medicare and the complex ways policies influence one another. For historians of medicine and immigration, this work adds a corrective to the literature because it emphasizes the integral role foreign-trained doctors played in the realization of Canadian Medicare. And for health policy experts, physicians, politicians, and the public, Mullally and Wright’s transnational history adds necessary perspective to the well-publicized doctor shortage. They show that access to physicians has always been a problem in Canada, and the entire system suffers from a frequent lack of doctors in difficult-to-service areas.³⁸ In the end, Mullally and Wright outline the complex history of foreign-trained doctors and how Canada was well positioned at the crossroads of their transnational medical migration. As they

34 Mullally and Wright, *Foreign Practices*, 226–7, 228, 230, 250, 237, 252.

35 For a description of the behaviourist approach in the history of medicine, see Erwin R. Ackernecht, “A Plea for a ‘Behaviorist’ Approach in Writing the History of Medicine,” *Journal of the History of Medicine and Allied Sciences* 22, no. 3 (July 1967): 211–4.

36 Mullally and Wright, *Foreign Practices*, 261–4.

37 Lux, *Separate Beds*, 70.

38 Mullally and Wright, *Foreign Practices*, 254.

persuasively argue throughout the book, between 1957 and 1984 Medicare and immigration intersected in ways that markedly transformed medical practice in Canada.³⁹

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39 Mullally and Wright, *Foreign Practices*, 254, 264.