

DIASPORAS ET INVESTISSEMENTS
POUR LE DÉVELOPPEMENT /
DIASPORAS AND INVESTMENTS FOR
DEVELOPMENT

8. Professional integration of African migrant doctors in France

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Policies that attract highly-skilled migrants have been increasingly promoted within the Organisation for Economic Co-operation and Development (OECD) countries (OECD 2008; 2010) with governments implementing specific procedures to attract and facilitate their mobility (Czaika & Toma 2015). However, professions are not treated equally when it comes to welcoming highly-skilled migrants (Czaika & de Haas 2013). The medical profession as a protected market is one example: in the United States (US), Brenton *et al.* (2013: 1) show how establishing occupational licensing regulations work as protectionist barriers to migrant competition. In Switzerland non-EU/EEA doctors can practice medicine in the public hospitals only under strictly controlled conditions and for a finite period of training time (Mendy 2014). In France doctors with a non-EU/EEA degree have a status with less professional prerogatives. The non-EU/EEA doctors, called *Praticiens à diplôme hors Union Européenne (PADHUE)*, are the subject of ongoing debate. They are tolerated but not fully accepted within the medical profession and are hired to fill medical staff shortages in specialties and locations where French doctors do not want to practice (Mendy 2016). The situation in France can be traced back to the Code of Public Health, which defines the status of a doctor and the conditions of medical practice. It legally differentiates between medical graduates from France and EU/EEA countries and foreign doctors with non-EU/EEA degrees. By definition practitioners with non-EU/EEA degrees are divided into three subgroups. Firstly, those who originally arrived for professional or academic reasons and remained in France once their initial official reasons for staying concluded, and who work in France under the conditions fixed by the French Code of Public Health. Secondly, those who studied medicine in France.¹ For these first two categories,

1. Although not the same curriculum as French students because they are accepted within the eight per cent quota dedicated to foreign students in medicine, while French students are selected through the

migrants are supposed to return to their countries of origin once their study or specialisation is finished. However, if they wish to stay and practice medicine in France they must successfully complete the Authorisation Procedure Exercise (PAE)² to obtain assistant practitioner status, which only gives them limited rights as a doctor. Finally, those who fail the PAE represent the third category. Officially they are not permitted to practice, although many found in this group are practicing medicine.

Despite occupying numerous positions and contributing to the functioning of public hospitals (Cash & Ulmann 2008; Cottureau 2012; CNOM 2013) the status and salary of doctors with a non-EU/EEA degree are lower than doctors with French or EU/EEA certification. This situation is very often the subject of social conflict between their unions and the French governments seeking to limit their recruitment. Since the 1980s, and despite several attempts at reform, French authorities have failed to limit the recruitment of non-EU/EEA doctors. The Government's inability to limit the flows of non-EU/EEA doctors has been the subject of often impassioned debate in public discourse and encounters a certain opposition and hostility from the medical profession corporation, with limited agreement on either side. The only point of consensus among researchers interested in the issue of non-EU/EEA doctors in France is it is of a complexing and puzzling nature (Deplade 2009; 2011; Coufinhal & Mousquès 2001a; Le Breton Levillois 2007).

Based on the path dependency approach (David 1985; Pierson 1996), which attaches great importance to historical factors as key explanations, and the empirical data gathered from field research, this analysis aims at understanding what makes the French case specific in recruiting non-EU/EEA doctors and why it remains unresolved, despite numerous attempts at reform. This chapter argues that the situation of non-EU/EEA doctors in France derives from a complex historical process of interaction between standards settled in the past, particularly the historical power of medical corporatism represented by the French College of Physicians, and the unexpected long-term effects of the hospital reforms of 1958 and the 1980s, coupled with budgetary pressures.

numerus clausus examination. Only students whose score equal to or better than those French students at the bottom of the required ranking are successful candidates (Cash & Ulmann 2008: 55).

2. The *Procédure de validation des acquis* takes place in three stages. A theoretical and practical examination in the form of hospital practice in a public institution for three years under the responsibility of a chief physician; a transition to a licensing commission may issue a temporary or permanent authorisation, registration with the College of Physicians and pending the approval of the practice of medicine. During the procedure for authorisation to practice, medical doctors outside the EU have the following status. They are hospital physicians, assistant or associated assistant when they prepare their theoretical and practical examination; a result of the authorisation procedure, they get the status of assistant practitioner.

After presenting the methodology, the theoretical framework and the status and characteristics of non-EU/EEA doctors in France, this chapter will review the three key explanations mentioned previously to better understand the issues which restrict non-EU/EEA doctors professionally integrating into the French health system.

I. Methodology

This chapter is based on research undertaken on the international migration of Doctors with African degrees in the United Kingdom (UK), France and Switzerland. The data utilised in this chapter was collected during the French case study (Paris 2006). The case study involved 15 semi-structured interviews with doctors with African degrees, interviews with the union of doctors with non-EU/EEA degrees, and finally the employee responsible for the recruitment of foreign health personnel in the Ministry of Health. Doctors with African degrees who were interviewed presented three different profiles: (1) they had done their medical studies in France – selected from a quota of eight per cent of foreign students; (2) they were doctors who had completed part of their training in Africa but completed and qualified in France, and finally (3) those who had graduated in medicine from an African university and obtained the title of doctor with the right to practice medicine in their country of origin. The age range was between 34 and 56 years, and the doctors interviewed were selected primarily through the 'snowball' technique using the African university networks. This presented a limitation in terms of the gender distribution in the sample and therefore differences in male and female careers have not been a singular analysis. In addition to interviews, a review of literature was conducted and discussions forums dealing with the employment of foreign doctors were analysed.³ The

3. The first article is published by France 24, '*Foreign doctors, second-rate practitioners in France.*' Wednesday, June 18, 2008. In the article Geraldine Desqueyroux-Quidu explains that, to cope with the shortage of doctors, France is forced to recruit foreign doctors. She highlights the fact that the PADHUE face not only the problems of wages but also integration. Their practice of medicine is limited in public hospitals where they are placed under supervision of a department head. This is the reason why they are categorised as 'second-rate practitioners.' The second article published by TFI News, '*Swirls on the free installation of foreign doctors*' February 12, 2009, gives an account of the reactions to the vote in the Senate, which offered the opportunity to non-EU foreign doctors trained in France to open a free consulting room. A decision which caused hostile reactions in the French medical public, especially from the College of Physicians and the union of private practitioners. The spokesman of the College of Physicians interviewed by TFI said that he is concerned, by the cases of foreign doctors 'completing' only their basic training, which in comparison to a French degree is, he considers, 'insufficient'. The third article published by the newspaper *Liberation*, "Foreign doctors: We are exploited and thrown away" March 4,

scientific interest of these discussion forums lies in the fact that contributions are numerous and anonymous, as a result participants in these forums do not censor their views. On this point, most of the statements reviewed confirmed the results of the interviews and the literature review. From a scientific standpoint, an important factor to consider in the analysis of blogs or readers' mails or views as empirical material is to take into consideration the context in which they occurred: in what context, for what purpose and if possible, who wrote it, and for whom it was written. When analysed in this manner speech can be used in sociological analysis alongside an interview, provided you avoid making it tell more than it can say. But, from a methodological point of view, the precautions are not very different from those prevailing in the use of conventional materials such as qualitative interviews.

A. The path dependence approach as an analytical framework

B. The non-EU/EEA doctors in France: status and characteristics

From a historical perspective, the path dependency approach helps to explain the structuring of french medical profession. It can be used to clarify how the unexpected long-term effects of french hospital reforms of 1958 created budgetary pressures, which constrained, until now, the employment of non-EU/EEA doctors. Briefly, the concept of path dependency is an essential element of the theory of institutional change. It has led to several disciplinary interpretations (cf. Greener 2005; Sewell 1996; Thelen 1999; Merrien 1990; North 1990; Mahoney 2001; Pierson 2000; Steinmo 2001) and it is borrowed from the work of the economic historian Paul David (1985)⁴. It highlights the fact that an optimal decision taken at a given time can have long-term dependencies and constraints accompanied by sub-optimal effects, and that technological or economic development does not necessarily lead to the most efficiencies. A classic example of 'lock-in' technology is that of the typewriter keyboard (David 1985). The assumption here is that when a track is followed it becomes irreversible, even if it would lead to sub-optimal outcomes

2009, follows a demonstration organised by the PADHUE where they highlight their difficulties to practice medicine in France, including the compulsory medical exam, which they consider 'grossly' selective for obtaining diploma equivalence. The article is illustrated with a picture of foreign doctors demonstrating in front of the Ministry of Health. On the signs, we can read 'Stop Modern Slavery in hospitals'.

4. The QWERTY system was invented to slacken the typing speed at a time when too much speed had the effect of locking the keys. Even if the problem does not arise today, new keyboards on the market, although technically optimal, are not used (Merrien 1990).

(Thelen 1999: 385). In the new institutionalism perspective, this means that institutions⁵ do not easily change (Immergut 1998; Pierson 1996; Steinmo 2001). Even if the institutional structure is not satisfactory, it becomes very difficult to change the rules. Indeed, the cost of uncertainty, which involves a new institutional structure sometimes makes actors unwilling to change the structure (Shepsle 1986; Steinmo 2001). According to Mahoney (2000) there are three common and converging points of analyses using the path dependency: First, they all involve a study of causal processes highly sensitive to events that occurred in the past within a global historical order. Secondly, the logic of the path dependence process implies that past historical events are contingent outcomes, which cannot be explained on the basis of past events or initial conditions. Finally, once the historical contingent events take place, the sequences of path dependence are marked by relatively deterministic causal models or what can be called inertia. When using the path dependency approach to explain medical migration some limitations are apparent, which prevent it from being used to completely interpret the non-EU/EEA issue in France. In fact, as a theoretical framework, it becomes insufficient to explain further transformations, which have occurred surrounding the issue of non-EU/EEA doctors, namely the impact of negotiations and various reforms undertaken by the French government. To address these limitations, we also consider the policy change perspective (Kingdon 1984; Steinmo, Thelen & Longstreth 1992; Joppke 2007; Schmidt & Radaelli 2005; Streeck & Thelen 2005), which allows us to interpret the impact of reforms on the medical profession and how they maintain non-EU/EEA doctors in an inferior professional position.

B. The non-EU/EEA doctors in France: status and characteristics

According to the Code of Public Health, for a doctor to officially practice medicine in France they must meet three cumulative conditions laid down in Article L.4111-1 in the Code of Health (Deau 2006): (1) 'Having the nationality as stipulated in the text; (2) Be a holder of diplomas under Article 4131-1 of the Code of Public Health; (3) Be registered in the College of Physicians' (CNOM 2012b).

Considering the statues under which non-EU/EEA doctors are working within the French health system, we can distinguish two groups. The first category, and the most important, is

5. The definition of institutions, as envisaged in the institutionalism perspective, is that institutions are not the passive recipient of social demands (classes, groups, preferences) or a result of their actions, but they have a fundamental effect on political and social events by influencing actors, and the way in which they define their interests and identities (Mahoney 2000; North 1990; 1991; Pierson 2000; Steinmo 2001). In other words, institutions are not neutral arenas; they distribute power unequally between groups and social workers and promote or limit collective capacity of action (Merrien 2002).

composed of those who are not recognised fully as doctors, meaning they are not permitted to be included on the list of the College of Physicians, and can only practice in public health institutions if they are formally under the supervision of a doctor with a French degree. Among them, we can distinguish: Contract Assistant Practitioners (CAP) and those working under various statuses – attached practitioner associates, associate assistants, acting as intern ‘Faisant fonction d’Interne’ – within the hospital system. They have all been granted the right to practice in public hospitals. The second category which has been called the ‘unauthorised’⁶ refers to the non-EU/EEA doctors who are unable to get integrated into the hospital medical profession via authorisation procedures but, nevertheless continue to practice medicine through subterfuge used knowingly by hospital administrations (Couffinhal & Mousquès 2001a; Le Breton-Lerouillois 2007). This last group practice medicine, recognised by all the stakeholders of the system, although they have no formal right to practice.

Officially, there is no consensus surrounding the number of non-EU/EEA doctors (Cash & Ulmann 2008) practicing in the French health system. According to the database of the College of Physicians, in 2013, 92.2 per cent of physicians in France are doctors with a French diploma, who meet all of the criteria within the French medical curriculum (CNOM 2013: 109). European and non-EU/EEA graduates represented 7.8 per cent of all doctors registered by the College of Physicians. This represents, in terms of numbers, 21,111 graduates, with 9,642 from EU/EEA countries and 11,469 from non-EU/EEA countries (CNOM, 2013:109). Within the non-EU/EEA staff, 66.3 per cent have obtained their degrees at a university in the Maghreb, with the majority from Algeria (40 per cent) (CNOM 2013). The top ten countries where non-EU/EEA doctors originate from, recorded by the College of Physicians, is Algeria (40 per cent), Syria (11 per cent), Morocco (10.5 per cent), Tunisia (4.8 per cent), Madagascar (3.9 per cent), Lebanon (3.6 per cent), Federation of Russia (2.3 per cent), Argentina (2.2 per cent), Egypt (1.8 per cent), Senegal (1.6 per cent) (CNOM 2013:111). In fact, most of the non-EU/EEA doctors are French citizens who acquired French nationality during their stay, or French citizens who have been trained outside of the EU/EEA countries. The data from the College of Physician is often challenged by the non-EU/EEA doctors’ unions as a majority of them are not recognised by the College of Physicians and consequently do not appear in their database. In 2008, one of the non-EU/EEA unions – Federation of Health Practitioners – estimated non-EU/EEA doctors to number 17,000 in France (Cottureau 2012a: 1). It has been estimated that 63.5 per cent of foreign doctors with non-French diplomas work primarily in the public sector, in rural areas which face a shortage of medical professionals, while 46 per cent of doctors with French diplomas primarily practice

6. It particularly deals with those who are ‘denied to sit the examination for Certificate of Clinical and Therapeutic Synthesis’ those who fail the examination for Contract Assistant Practitioners, those who are in specialties non-validated by consultation commissions, practitioners who are graduate doctors but registered as students.

in the private sector where they have the ability to supplement their State salary by charging private rates (CNOM 2013: 117).

II. Employment and professional integration of doctors with non-EU/EEA degrees: between corporatist refusal and necessities

The employment of doctors with non-EU/EEA degrees in France provides a remarkable illustration of the path dependence approach. Understood in the context of this analysis and briefly summarised, this means that the inherited institutional health system is the result of some fundamental moments that punctuate the history of medicine and the medical profession in France. In France, the issue is not foreign doctors, but that of doctors with foreign degrees. Following this logic, the situation of doctors with non-EU/EEA degrees lies at the confluence of two forces: first, building a corporatist legitimacy over the years by the *numerus clausus* examination in medicine and secondly, the budgetary pressures that result in difficult to fill places being given to doctors with non-EU/EEA degrees in the French hospital system.

A. The construction of medical corporatism in France: Medical profession as closed labour market

First of all, the medical profession in France is officially known and defined as corporatist (Dubar 1996; Hassenteufel 1997) and a closed labour market (Paradeise 1984; Immergut 1992). It is institutionalised as such on a legal basis by the State. Among the characteristics shared by a corporatist and closed marked organisations, which can be seen in the medical profession, is a tendency to protect and defend the interests of their members and hostility towards reform. Following Paradeise's (1984) broader definition, closed labour markets are defined as those social spaces where the allocation of the labour force to employment is subject to impersonal rules of recruitment and promotion. Markets are so-called closed because they feed off themselves at the lowest pyramids in each grade level, with the senior positions being filled by internal proposal. The main common characteristic of a closed market is the protection of workers they employ against competition on the open labour market and more broadly, against competition between colleagues: 'the characteristic of these markets is the existence of a "super-rule" that articulates the interests of workers and buyers of the workforce using procedures that are beyond the laws of the free market.' (Paradeise 1984: 357).

1. The imprint of the past

The current situation regarding the recruitment of non-EU/EEA doctors in France has been caused by the structure of the medical profession, the role of the government in the health sector, the selective employment route into the field (Freidson 1985; Hassenteufeel 1997; Herzlich *et al.* 1993), and budgetary pressures (Immergut 1992). First and foremost, from the early twentieth century, French doctors have succeeded in frustrating attempts to incorporate the profession into a binding national health insurance system (Ferro 1985; Leonard 1981). In 1927 they adopted the *Charter of the Liberal Medicine*,⁷ which involved the creation of a professional corporation with extensive powers (Hassenteufeel 1997: 18). According to Hassenteufeel neither the *Social Insurance Laws* of 1928 and 1930, nor the implementation of social security after 1945 succeeded in questioning their professional prerogatives and powers over the practice of the profession. Hassenteufeel stressed that by the end of the 1920s, in a context where xenophobia and anti-Semitism were rising, professional associations of French doctors launched a campaign to defend the principle that the medical profession should be reserved for French doctors.

The corporatist ideology of the French Action, 'l'Action française' gradually penetrated the medical profession over a period of 20 years. It became the dominant public discourse of the profession, whose main spokesmen gathered in 1929 within the corporatist medical group and whose words were inspired by the far right. Xenophobia, in the sense of Deplaude (2011),⁸ was fuelled by the dramatisation of the large number of foreign students who passed their medical degree. In addition, risks to the income of the profession, particularly reflected the rejection of foreign doctors who were considered as a threat to the morality of the job (Hassenteufeel 1997). As written by Henri Nahum:

From the years 1920 to 1930, the number of doctors increased. Medical unions and Deans of medicine were alarmed by this plethora: when we hardly expect new medical advances, it surpasses by far the needs of the population and the risk of impoverishing the medical profession. This plethora is mainly attributed to the 'invasion of these wogs',

7. The 1927 Charter is composed of seven principles: the free choice of doctor by the patient; absolute respect of professional secrecy; right to fees for any patient treated; direct payment of fees by the patient (refusal of third party) and fees freely determined by the doctor - called principle of the direct agreement between the doctor and the patient; therapeutic freedom and prescription; control of patients by the cash-desks, doctors by the union and the medical arbitration committee – refusal of any control of doctors by cash-desks; union representation in the cash-desks.
8. Inspired by Miles & Brown (2003), Deplaude (2011: 189) defines xenophobia 'as on the one hand the act of categorising individuals according to their real or perceived nationality and, secondly, to assign negative characteristics to groups thus constituting or presenting them as a threat to other groups.'

accused of incompetence, and a lack of ethics and complete ignorance of French traditions (Nahum 2008: 42).

In fact, the College of Physicians continues to defend the idea of an institution responsible for keeping the principles of morality, integrity, and dedication necessary for the practice of medicine and observation of rules laid down by the Code of Ethics. The Ambruster Act, which remains in force and imposes three restrictive conditions to the practice of medicine in France: French nationality, the possession of a French diploma and registration with the College of Physicians. The only exception was the introduction of the Individual License to Practice Act 1972 which established the granting of individual licenses to practice to foreign doctors (Couffinhal & Mousquès 2001a).

2. The role of certifying and excluding from medical training: the French *numerus clausus*

The exclusion of foreign doctors was further strengthened with the adoption of the *numerus clausus* examination in 1971, which was introduced by Simone Veil. In general, the term *numerus clausus*, is an entrance examination which students take to be admitted onto a particular course, mainly in regulated professions, with the highest scoring students taking course places (Hardy-Dubernet & Faure 2006).

In France, the first year of medicine is marked by lectures and at the end of the first year an exam provides access to the second year, or not if the student does not pass, and marks the end of the first year of undergraduate medical studies.⁹ The *numerus clausus* plays a key role in structuring the French medical profession as a 'closed profession' (Dubar 1996; Paradeise 1984; Seguestrin 1985) and consists of ranking candidates, with the numbers admitted fixed by regulation. It has two fundamental characteristics: first, it is reserved only for French students and therefore foreign students cannot, by its very definition, sit this selective examination; second, it is based on a quota system for entry into the second year. The number of positions offered is very low compared to the number of students registered in medical school.¹⁰ Unlike other established admissions procedures implemented in different European countries, this procedure ignores student motivation and previous social experience, instead it takes the form of multiple selected questions (MSQs) on scientific issues (Hardy-Durbernet & Faure 2006: 15).

9. A reform of the medical training has been in force since September 2010. We now speak of First Year of Medicine Studies (PACES) and General Medical Sciences Training Diploma (DFGSM) (ANEMF 2014).

10. Deplaudé (2009) provides a historical analysis of political and administrative issues of the *numerus clausus* in France thanks to a thorough search of administrative records.

The preparation for *numerus clausus* competition for the young students requires a considerable workload. As Verdoot, points out, the *numerus clausus* is synonymous with 'anxiety' for students who undergo it. Verdoot describes it metaphorically as a source of 'nervous tension before the results, a vague and distant future, the fear of the wall, the uncertainty for further studies.' (2000: 1). However, success in the exam demonstrates within the medical profession and more broadly within French society, the quality of French medicine and the value of its practitioners. For the large majority of the French social body, the *numerus clausus* examination is the only legitimate form of selection, with the dominant view being that justice and fairness require that jobs within the French medical profession should be reserved for those who have succeeded in this difficult rite of passage (Deau 2006; Hardy-Dubernet & Faure 2006; Deplaud 2011). Symbolically, the *numerus clausus* examination demonstrates an important distinction of competence between doctors with French degrees and doctors with foreign degrees, labelling those lacking the *numerus clausus* as illegitimate doctors.

The social construction of a competent doctor versus the less competent doctor (Dubar 1996: 18) is imposed with a crystallisation of historically stubborn prejudices, either they are objective or subjective, implicit or explicit. Generally, such prejudices tend to be rooted in the views of public opinion (Dodson & Oelofse 2000:126) and are often replicated ironically by the media (Pinel 2006; Mouataarif 2006; Desqueuroux-Quidu 2008; Piquemal 2009; Piganeau 2011). Non-EU/EEA doctors therefore, see themselves confined to occupy a constricted position on the outskirts of a profession whose interests are jealously preserved through political advocacy of the corporation (Hassenteufel 1997; Immergut 1992; Seguestrin 1985). In comparative analysis, the highly elitist medical training and the idea that training in France is of superior quality, explains the low opinion of the non-EU/EEA medical workforce (CNOM 2013). However, this is only one of the key explanations of the problem of foreign doctors. To understand the overall logic of the French healthcare system, it is important to take into account the effects of modernisation in the hospital sector undertaken by the Hospital Reform 1958 (Cash & Ulmann 2008).

B. Unexpected long-term effects of the 1958 and the 1980s hospital reforms

At the beginning of the Fifth Republic, the French government began an ambitious reform of the hospital sector: the 1958 Debré reform (Haroum 1969). This reform upset both the relationship between private practice and the hospital sector, as well as medical training it created new hierarchies and new requirements. After the 1958 reform, all students who had crossed the threshold of their second year of study were to be trained within hospitals through an internship. An internship in a hospital was possible after an examination, which allowed

students to hold paid positions in hospitals during the duration of their postgraduate medical courses. In this system, all medical students have access, at the end of the seventh year, to the grade of Doctor of Medicine after defending their thesis. This title also allows everyone to practice general medicine. Specialisation is done in two ways: either by an internship in a hospital, the only means of access to surgical specialties, or by the Certificate of Specialized Studies (CSS), (Hardy- Dubernet & Faure 2006: 11).

The establishment of a hospitals' elite and the adverse effects of the 1982 reform

Internships for a specialty were established by the Law of 31 December 1982. With the internship specialty and intern positions dependent on national legislation, while positions for the CSS were left to the discretion of the Faculty (CNOM 2012). Doctors in CSS positions received no pay and have no official position in the hospital where they practice their internship. Regulating the access to specialties allowed the government to limit the number of positions in any given specialty. However, the 1982 reform failed in its ambition to upgrade general medicine as it still could not attract the best medical students (Hardy-Dubernet & Faure 2006: 12). This reform was eventually seen to have negative impacts and was abolished in 2004 and replaced with the National Classifying Competitions (NCC). The NCC officially became the sole and mandatory passage of all medical students in France (Hardy-Dubernet & Faure 2006). This series of measures led to a lower number of students and French graduate doctors in hospitals, which caused a drastic shortage of personnel.

The 1980s brought a transformation of political ideology in France, which was influenced by international political thought regarding the reduction of state based welfare. Control of health expenditure became an important issue after the failure of several attempts to restructure the sector (Cash & Ulmann 2008: 61; Merrien, Parchet & Kernen 2005: 345-347). According to the expectations of this period, reducing the number of doctors would also lead to a reduction in medical prescriptions and therefore significant savings in social security payments. This solution, which at the time gained unanimity among many actors, was quickly challenged by the Deans of Medicine Faculties and the College of Physicians (Cash & Ulmann 2008: 61).

The 1958 hospital reforms thus set a hierarchy and rigid separation between the noblest hospital functions and private practice, which is less worthy but relatively independent. It also created new needs, which were difficult to meet in the framework of existing hierarchies and budgetary constraints. This contradiction led to the unintended consequence of the need to recruit graduates from outside the EU/EEA. Moreover, Xavier Deau, former President of the French College of Physicians, emphasised that the '*numerus clausus* imposed on French

students (...) is one of the aetiologies of the massive influx of foreign students since the 1990s.' (Deau 2006: 2).

C. Difficulties in responding to the needs

Despite the intent to reduce hospital expenditure the reforms of public hospitals led to an increased medicalisation of hospitals, which has resulted in a higher requirement for doctors (Cash & Ulmann 2008; Couffinhal & Mousquès 2001a). The greater need for doctors can no longer be filled through the usual channel of medical students who have passed the internship. The declining number of doctors graduating through the French system has led hospitals to employ, in important proportions, doctors with foreign degrees. This policy is easy to implement as many doctors from the Maghreb and the Middle East settle in France for both financial and political reasons. Controlling the influx of doctors with non-EU/EEA degrees and, through the principles of the law, for deploying them where French doctors do not want to practice is a political and strategic choice legally established (Deplaude 2011). This policy is also implemented in a context of social protection deficit (Merrien, Parchet & Kernen 2005: 347).

State prerogatives: governments between the needs to rationalise and budget constraints

From the 1990s onwards, successive governments have tried to rationalise the employment of doctors with non-EU/EEA degrees in hospitals without putting an end to jobs considered essential to the functioning of hospitals. As early as 1991, the French government intended to correct the situation by restricting recruitment opportunities of non-EU/EEA doctors. The 1991 Act stopped the recruitment of non-EU/EEA doctors but it did not consider the actual impact this would have. Indeed, it quickly became apparent that hospitals would cease to function without this labour force. At the same time, the government's measure to reduce the recruitment of non-EU/EEA doctors encountered resistance from the non-EU/EEA Unions who denounced these measures and requested that non-EU/EEA doctors be officially recognised on a par with their French counterparts. This was an impossible request for the French Government to satisfy for two main reasons. First, it would require a significant budgetary increase in an ideologically and economically hostile environment. Second, it would mean the Government would have to contend with opposition from the French doctors' union who are strongly opposed to the recognition of non-EU/EEA doctors and their requests for similar rights to French doctors.

Finally, what the French Government did, was to postpone indefinitely the date of the implementation of the measures from the 1991 Act. In 1994, the debate was revived but without any effect on fulfillment of the 1991 Act. The year 1995 marked the culmination of the reformists' will. On February 4 1995, the Weil Act, executed in a context of fiscal crisis and xenophobic tensions, was presented as a law for the integration of doctors with non-EU/EEA degrees into public hospitals. The 1995 law was divided into two parts: first, the law created a new examination for a additional status called CAP. Unlike other hospital doctors, CAPs are not permanent but contractual. However, faced with the implementation difficulties the Act was repealed in 1997. In 1999 a new status of doctors with a foreign degree were integrated into the law on universal health coverage. The Bernard Kouchner law (1999) meant access to the practice of general medicine was expanded by increasing the annual quota. Permission to practice general medicine was given to non- EU/EEA doctors practicing for over six years in hospitals. However, the Kouchner Act (1999) fixed the deadline of integration to happen by 2001, and at the same time prohibited the recruitment of any new graduates from outside the EU after 1999.

Nevertheless, it appears that the vision of French authorities to rationalise non-EU/EEA doctors has been defeated by different stakeholders. The first difficulty is that the demand for doctors in hospitals remains high. Due to budgetary constraints hospitals cannot afford to lose non-EU/EEA doctors as French doctors cost more to employ. Second, the College of Physicians have refused to recognise non-EU/EEA doctors to be at the same professional competency as French doctors. Third non-EU/EEA doctors and their unions consider the above proposals insufficient as they do not take into account their requests.

D. The interests of actors in the heart of the controversy

The analysis of the interviews conducted in Paris, as well as the literature review and discussion forums that follow the articles published on the situation of doctors with non-EU/EEA degrees in France, reveal much about the interests of the actors involved. All three sources highlight the same three factors which fuel the controversy surrounding the professional integration of doctors with non-EU/EEA degrees: the *numerus clausus* examination and the failure to obtain a French diploma, working conditions and the non-recognition of qualifications. Beyond these points mentioned, the data also showed that discrimination of non-EU/EEA doctors is widespread. They persist in open discussions and, as we mentioned previously, are replicated by the media.

The speeches by the French authorities, whether administrative or from the College of Physicians, officially build on the basis of the French legislation and more broadly, on the ethics of development that wants non-EU/EEA doctors to return to their countries of origin to treat their own (Deau 2006). According to the health authorities, the laws are clear on the situation of doctors with non-EU/EEA degrees. For the official in charge of the medical profession in

the Ministry of Health (October 2006), the legal procedure for non-EU/EEA doctors has no ambiguity in its formulation, contrary to what their unions say. If his explanations brought nothing new in regard to what the legal procedure provides, he did present, through his explanations, a greater understanding of what doctors with non-EU/EEA degrees could expect. Indeed, he said, the latter must not delude themselves about their actual status even after validation of their authorisation to practice, which is merely a certificate, valid only in France and not considered a diploma.

Yet, the discourse of French authorities contrasts with several attempts to find solutions and alternatives to the non-EU/EEA doctors, as well as to mark a break with the political choices of the past. Therefore, from a political logic, the difficulty in changing the rules, can lead the political and administrative actors to consider 'pragmatic rules' (Bailey 1971, cited by Deplaude 2009). These pragmatic rules consist of postponing deadlines until there is a more favourable and less sensitive time to address the union's demands.¹¹ According to Deplaude:

The pragmatic rules consist in presenting the problems and the answers given to them in publicly acceptable terms. Finally, they consist in gaining time, that is to say, trying to delay the adoption of the most politically risky decisions at a more convenient time, and then implementing them progressively according to changing circumstances and political power relations (Deplaude 2009: 20).

As to the issue of doctors with non-EU/EEA degrees, the constraints of providing them with official recognition goes beyond finding a convenient time. It would also require the means to negotiate with doctors with French degrees and the professional organisations which represent them, who are a significant pressure group within French society. This logic can also be seen in the official position of the French Government, which reinforces the superior positions of doctors with French degrees and defends their interests, which is again mirrored by official declarations from the French College of Physicians.

Firstly, the vast majority of doctors with a French degree, considers it a legitimate norm that a dualisation operates within the French healthcare system. For some, foreign doctors who have not been submitted to the *numerus clausus* and the selective training requirements cannot be recognised as full doctors. Full doctors are said to be those who have passed the *numerus clausus* examination, and therefore there are serious doubts about the competence of doctors with non-EU/EEA degrees particularly those who come from Africa.

11. Deplaude, has shown how the establishment and implementation of the *numerus clausus* of Medicine, in France in the 1970s, has created some of these pragmatic rules (Deplaude 2009: 20). This purely political logic explains why so many students have continued to be welcomed into medical school several years after the implementation of the *numerus clausus*, which has contributed to an unprecedented population growth of the medical profession in France.

Secondly, through analysis of official statements given by the College of Physicians, as a corporatist organisation, it can be seen that their rhetoric matches that of the French Government. Briefly summarised, the dominant and official position of the French government, is that employment priority should be given to French doctors, and then European doctors. However, employers have to be careful vis-à-vis doctors from new EU countries (Bulgaria, Romania) as their medical qualifications have also been questioned. Finally, there should be a limited acceptance of doctors with non-EU/EEA degrees because, for ethical reasons, they should return to their countries of origin to help their own populations once they complete their training. This return will be both beneficial to their countries as well as to the French students who will find jobs:

Is it not a way of depriving these people of their doctors and the country of their elite?
Is it not a way for our university to live vicariously at the expense of foreign universities?
Is it not a way of depriving our children of desirable access to university to train them for a profession which, moreover, has real needs? (Prof. Jean Langlois, President of CNOM, BOM, No. 15, May 2003).

Presently, the College of Physicians has not denied that it has needed to fill a personal deficit with non-EU/EEA doctors, despite the reservations mentioned. From this point of view, if the choice is between European doctors and non-EU/EEA doctors, then the preference is for EU/EEA members. Moreover, European enlargement to Eastern countries poses many problems and requires a minimum guarantee of competence mainly because of heterogeneous paths:

In France, we have a shortage of doctors in some areas. We are not going to deny those who knock on our doors when they offer all the guarantees of skills ... but probably mechanisms should be put in place to regulate migration flows of the medical profession (Xavier Deau, BOM, No. 3, March 2006).

The African doctors, with non-EU/EEA degrees, that we met in Paris contest the official position. When they described their professional trajectories, they said they did not understand why they are not professionally integrated despite several years of practice in France. They all considered themselves victims of discrimination and said they had been shocked by the speeches which portray them as 'second-rate doctors' (Pinel 2006). Despite persistent prejudices against their training, doctors with non-EU/EEA degrees, state that they are as competent as their French colleagues (Piquemal 2009). The survey revealed that there is constant disillusionment among them as they are faced with a career as a 'blocked' professional, which is defined as 'a model in which the African graduate in medicine cannot undertake a professional career in conditions identical to those of national conditions. This model is characterised by high barriers to admission, non-recognition of diplomas, and a national/non-national dualism in the exercise of the profession.' (Mendy 2014: 48). They also specified that they did not find a significant

difference between the medical training they received and that which is taught in France, as the medical teaching in African universities is designed based on the French model and is supported by numerous doctors and professors from France.

The current procedure (...) is much more selective than any other hospital competition that exists in France (...) and I'm not talking about the three years of exploitation as a sub-doctor, (the one) who works more than colleagues to get the average, and often it is much more than three years. (D6 France, October 2006)

After developing the key explanations for understanding the situation of foreign doctors in France, and the issues related to the interests of different actors, I now turn to discuss the limitations of the path dependency approach in explaining the case of non-EU/EEA doctors in France.

III. The theoretical limits of path dependency to explain the policy reforms

In short, the path dependency approach helped explain how the issue of doctors with non-EU/EEA degrees in France have been impacted by the historical structuring of the French health system. However, it can not theoretically explain how the reforms, with regards to the issue of the professional integration of foreign doctors, occur in France (Steinmo, Thelen & Longstreth 1992; Pierson 2000).

In fact, the situation of foreign doctors is not subject to an inherent determinism. The labour negotiations and the various public reforms implemented since the 1980s and 1990s allowed the regularisation of a large number of doctors with non-EU/EEA degrees. Contemporary studies have recognised the failure of path dependency theories to account for social change. In many areas, there seems to be much less inertia than has previously been assumed (Mahoney 2000).

National policies, even when considered relatively stable and included in national heritages such as economic and social policies (Scharpf & Schmidt 2000) or migration policies in Europe (Joppke 2007), have suffered severe transformations that have erased their original features and lead them to a form a convergence. These transformations have been traditionally explained by theorists belonging to the school of historical neo-institutionalism as the result of 'critical junctures' or periods of 'third-order change' (Hall 1993), when public debates serve to reframe the issues and moments when a 'window of opportunity' (Kingdon 1984) opens and the search for a new policy program begins.

This type of explanation can account for fundamental change and a break with past policies under the influence of an altering frame of reference and the dominant discursive structure (Jobert & Muller 1987; Schmidt & Radaelli 2004). However, analysis has also shown that the majority of policy changes can be introduced over time and thus can be much more incremental. In *Beyond Continuity*, Streeck & Thelen (2005) sketch a systematic theory of policy change, where one of the most powerful aspects is a critique of the 'punctuated equilibrium model' based on the assumption that long episodes of institutional inertia follow rare 'critical junctures' during which exogenous shocks provoke massive path-departing institutional transformations. Although they do not reject the concepts of critical junctures and path dependence, they convincingly argue that most forms of policy change occur outside such episodes, and that they often take an incremental form.

When we look at the situation of foreign doctors in France, in light of recent work on social change, two significant results appear. First, it is undeniable that the French medical system has undergone a series of transformations unthinkable in the strict sense of the path dependence approach, characterised by the 'inertia' (Mahoney 2000). These transformations fit perfectly with the logic of 'institutional layering' analysed by Streeck & Thelen (2005). Indeed, in the context of the Europeanisation of public policies, European doctors, who have not been subjected to the *numerus clausus*, had to be accepted as legitimate doctors in France. The aging French population and the inadequate number of physicians trained in the 1970s and 1980s, forced France to recruit foreign doctors and to increase the quota of restricted intake. Finally, to meet the needs, and in the context of limited public budgets, many non-EU/EEA doctors could practice medicine within the hospital system, but very rarely in private practice. The creation of the hospital sector combined with the pressures and employment needs, alongside the public financial crisis has also led to the recruitment of doctors with non-EU/EEA degrees that are not recognised as doctors by the College of Physicians.

Second, even though there is a series of transformations, there is no change to the overall paradigm. Non-EU/EEA doctors are not considered legitimate doctors even if they have the qualifications of physicians, which are legitimate in their country and are recognised in other countries (e.g. the UK). In France, it remains that they may engage only in subordinate roles. Significantly, the recruitment policies for non-EU/EEA doctors continue to highlight the impact of the past and reveal a considerable persistence of prejudices that some authors, such as Mbembe (2005a; 2005b) stressed when they talked about colonial practices. Indeed, in colonial times, foreign doctors coming from colonies could only occupy some medical auxiliary functions. Certainly, the combined pressures of the needs of the health system, their inability to recruit French or European doctors to unattractive jobs, and non-EU/EEA doctors seeking recognition of their rights, led to repeated attempts of their integration into the medical profession. But these attempts face the strength of deep-rooted prejudice in the French medical profession and elites, much more than in French society as a whole.

In this sense, the institutional systems are more than just a legal system. As pointed out by James, March & Olsen (1989; 1996), institutions are a relatively enduring collection of rules and organised practices, embedded in structures of meaning. The rules may change incrementally, but the structures provided create inertia. For example, in the context of the practice of medicine, discussion forums of French doctors that we have analysed show the existence of a deep-rooted 'colonial' attitude to African doctors and a view that their degree qualifications are insufficient. In France, even as the medical profession diversifies and opens its doors to a few foreign doctors (CNOM 2013) non-EU/EEA doctors must continually organise social movements (strikes, demonstrations) to be admitted into the French medical system.

Conclusion

This paper has shown that, when the French governments justifies the unequal treatment given to the professional integration of non-EU/EEA doctors, it invokes three main reasons. The specific status of medical profession as a 'closure market' (Paradeise 1984), the preference for the EU/EEA workers and, the ethical reasons, meaning the development arguments which assert it is unethical to recruit health professional from poor countries. The ethical argument is predominantly used by the French government in justifying their refusal to recognise non-EU/EEA doctors. Yet, the functioning of public hospitals in France is based mainly on the contribution of these doctors, who are often 'undocumented' (Lochak 1995), according to the definition within the French Code of Public Health. This paper has gone beyond the political controversy and has shown the role played by institutional legacies. It is through these combined perverse effects of policies, reforms and privileged status that the French dilemma in recruiting foreign physicians is to be understood.

Two significant theoretical findings have also been underlined. First, in the issues of non-EU/EEA doctors, the French medical system has undergone transformations which are unthinkable in the strict sense of path dependency approach: an opening of the medical profession to foreign physicians in the context of the Europeanisation of public policy, acceptance of non-EU/EEA doctors in a context of medical shortage and budgetary pressures. Second, even though reforms have been done, there is no change to the overall paradigm. The recruitment policies for non-EU/EEA doctors continue to highlight the imprint of the past (Merrien 1990) and reveal a significant persistence of prejudices (Deplaupe 2011). At the same time, the opening-up of the EU (Rea 2013) tends to restrict the possibilities for non-EU/EEA doctors to practice in France. Indeed, as far as recruitment is concerned, France is increasingly finding alternatives to physicians from new member countries of the EU. The officials of the French College of Physicians continue to draw on the dominant ethical discourse which denounces the medical migration from developing countries, even though the rhetoric is out of step with the realities

of most developed countries, in which medicine is a protected profession from an institutional point of view and closed by its internal functioning (Mendy 2016; Peterson *et al.* 2013). In addition, recent reports on medical demography in France (CNOM 2013; 2014) reveal that more and more French students are bypassing the *numerus clausus*, doctors are studying in other countries such as Belgium, then returning to work in France. Confirmation of these trends may further contribute to the marginalisation of non-EU/EEA doctors.

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