CHAPTER 6

The Navy SEALs and the National Guard

On a sunny afternoon in October, I asked a group of third-year Stonewood University Hospital residents what was different about training at a place like Stonewood compared to a community hospital. One resident, Lucy, replied with a shrug, "We're like the Navy SEALs and community hospital is like [the] National Guard." She continued:

LUCY: [As US-trained medical graduates], you become very homogenous in the way that you learn, the way that you think, the way that you approach a problem, and that's a big difference between [us and] the [international medical graduates]. . . . I mean I think that's why people want to be here, because it's like *the* place to be, *the* top; you see *the* patients; you do *the* stuff. (emphasis in original)Tania: Does this resonate with others?

TED: Well, I like the homogenous [thing] you said. Although the argument is . . . we are learning how to practice medicine the *right* way. (emphasis in original)

LUCY: That's what the system is trying to do.

TED: Right but . . . Like in martial arts, there are two different schools, but do you still get the job done?

LUCY: There could very well be another way and we just don't know it. [*entire group laughs*]

The laughter after that last sentence is telling. The notion that there may be a different or better way of practicing medicine than the way graduates of US allopathic medical schools [USMDs] were taught in university hospitals was laughable. They understood there to be two kinds of internal medicine residents: elite USMD "Navy SEALs," a "special breed of warrior" trained in tertiary

hospitals to handle the most complicated of patients and situations, and a reserve army of non-USMD "National Guard" forces assigned to take on simpler roles in community hospitals.[1]

Lucy's words perfectly describe status separation in internal medicine. The Navy SEALs and National Guard metaphor not only captures horizontal hierarchies *within* internal medicine training—status separation—but also points toward the formal vertical hierarchies that emerge after graduation as many USMDs specialize and many non-USMDs remain generalists. Recall that Freidson had predicted the emergence of a formal vertical elite and a rank and file within the profession to help protect against external incursions (as I described in the introduction).[2] He never addressed, however, the existence of informal horizontal hierarchies *within* specialties or how they might precede those more formal vertical hierarchies. By now, it should be clear that in internal medicine, informal horizontal status distinctions exist along educational pedigree lines, with USMDs in university residency programs largely going on to constitute the formal elite and non-USMDs in community programs eventually comprising much of the formal rank and file.

Unsurprisingly, many at Stonewood fully expected their trainees to become future *leaders* in the profession, while community practitioners were expected to be the *followers*. One official said matter-of-factly, "At a second- or third-tier hospital, those residents are arguably needier because they didn't come with the credentials that other residents have. [They] will do less well. By that [I mean] they won't lead the field; they won't be as good a physician as somebody who trained here [at Stonewood]." He went on to say, "I just don't think that the less distinguished programs have the capability or the track record to train leaders . . . [they are not] going to turn out from their program people who will be [chairs] and deans." This perspective was shared by the Stonewood housestaff, who viewed themselves as so distinct from community trainees that several had never even heard of some of the other medical residency programs in the area, including Legacy Community Hospital. One afternoon a group of residents in their third postgraduate year (PGY-3s) was struggling to name the community programs in the area when one of them interrupted: "But I think it's almost like looking at a football team, you know, it's like 1A, 2A, whatever . . ." He went on to explain that "it's divisions; we are in our own division out here. So there may be other programs in the state, but for our scope of programs, I mean the next closest ones are [*he starts naming large cities in neighboring states*]." Thus, Stonewood residents were

in a league of their own, untouched by the dozens of other residents training alongside them in nearby community hospitals.

For their part, non-USMD community hospital residents were widely considered gap fillers. One Stonewood official put it rather bluntly:

> The Caribbean people [US citizens who trained in Caribbean medical schools], they are picking up the scraps, and the foreign medical grads are having a death match. There is a level of desperation—you've probably met some of these people—who were like *friggin' orthopedics professors in Tehran, ophthalmologists in Karachi*. It's crazy. And they come over here, and they go into the family med programs or internal medicine programs or psychiatry programs, give everything up . . . (emphasis added)

From his perspective, non-USMDs—even highly trained subspecialists—essentially plugged holes in the US health care system by competing fiercely over whatever undesirable positions were left over. Non-USMDs made it possible for the most desirable positions to go to USMDs because they filled the spots that no one else wanted, effectively constituting a rank-and-file workforce for USMDs to lead. This same official went on to stress the importance of that rank and file: "People need doctors. People don't need chief residents. . . . The pinnacle of success in American academia is the physician-scientist. The guy who's got lots of NIH funding, [for whom] seeing patients is . . . a total afterthought. . . . We need people who are going to be on the frontline doing nothing but seeing patients." Without people on the frontline, the physician-scientist would be superfluous.[3] Non-USMDs made it possible for USMDs to become leaders because they provided the workforce to be *led*.

Importantly, many non-USMDs also viewed themselves as gap fillers, both during residency and afterward. Farha, an international medical graduate (IMG) and a PGY-2, described community hospitals like Legacy as "the places where American medical graduates don't come. . . . These small programs—foreign medical graduates and Caribbean [graduates] come here." Clark, a US citizen who graduated from an international medical school (USIMG) and a PGY-3 at Legacy, understood segregation in residency programs in a similar way:

> I mean I hate to say it, but [community programs] they're probably like, "Well, we don't have enough US graduates [to fill our program], so we'll

> take you." . . . And then these high-paying fields, . . . they fill them up with US grads. Not saying that there's no international medical graduates that have become radiologists; there are. But for the most part, that's the way it is.

Legacy residents thus understood that their role in the profession was to fill gaps toward the bottom of the medical status hierarchy—in lower-status specialties (like internal medicine) and in less prestigious hospitals (like Legacy) that USMDs did not want.

These residents might be thought of as the profession's equivalent to Bosk's "mop-up service"—a term used to describe how genetic counselors (who were physicians back in the early 1990s) would be called upon to do unpleasant work that others like obstetricians wanted to avoid, such as breaking terrible news to patients about genetic abnormalities.[4] Bosk's mop-up service, however, spanned several professional subspecialties within a single hospital, with one specialty (genetics) being subordinated to another (OB-GYN) and having to do the latter's dirty work. In the contemporary case of status separation in internal medicine, subordination spans a *single* specialty across the nation's hospitals. Also remarkable is the fact that Legacy residents did not experience the same kind of "status pain" that Bosk described as plaguing genetic counselors. Instead, most non-USMDs took on these lower-status, less desirable jobs willingly and even with enthusiasm—one could say they consented to this subordination or at least knew and accepted their place. This presents a puzzle: What beliefs sustain a system where a group of professionals willingly fills gaps for another group of professionals? In other words, to return to the earlier comment by a Stonewood official, why are those orthopedics professors from Tehran and ophthalmologists from Karachi readily filling "National Guard" roles in community internal medicine programs rather than competing with USMDs for positions in orthopedics and ophthalmology?

In the previous chapters, I considered how structures and resources differentially shaped residents' trajectories into, during, and out of residency, segregating and separating USMDs from non-USMDs in status. In this chapter, I focus on how respondents made sense of this status separation by exploring the belief system that supported status inequalities between USMDs and non-USMDs within medicine, resulting in highly prestigious and highly stigmatized identities based on pedigree. I examine how shared status beliefs help frame USMDs as more competent and deserving of top positions while relegating ostensibly

less competent and less deserving non-USMDs toward the bottom.[5] These beliefs were the product of both the game and the social contract of US medicine that I described in previous chapters and helped conceal the systematic structural inequalities that often passed for differences in merit.[6] These structures helped produce a "mental acceptance of a society's divisional structures," thereby making status distinctions between USMDs and non-USMDs seem natural and obvious.[7] As a result, non-USMDs *also* viewed USMDs as more meritorious, either because they thought USMDs worked harder or because they believed the country should prioritize its own. They therefore consented to occupying a subordinate status within a profession, and they counted themselves lucky to be part of it, given the tens of thousands of other applicants who would gladly take their place.

STATUS BELIEFS SUPPORTING USMD DOMINANCE

Overall, respondents felt that USMDs should have priority access to residency positions because they were better trained and more deserving than non-USMDs—meritocratic reasons that strongly resonated with the promises and expectations of the social contract. I discuss the complexities of these beliefs here, showing how some non-USMDs also subscribed to them and thereby contributed to USMDs' status dominance within the profession.

USMDs Are Better Qualified

The first belief supporting USMD dominance was that they were simply better doctors than non-USMDs. When I asked whether USMDs should be prioritized for residency positions, several USMDs thought that The Match should be an open competition and that residency programs should hire the best residents but that USMDs *were* the best. One USMD intern, for example, felt that resident selection should be based on merit but that USMDs were more meritorious anyway, so it "works": "Right now the marketplace aspect to the system seems to be doing a good job. It's a competition and the people who happen to be from here, who happen to go to US allopathic schools, happen to get the best spots for the most part. So for the most part, the system is working." From this intern's perspective, better outcomes were rightfully allocated to better candidates, therefore legitimating the system as highly meritocratic. Recall from chapter 2

that Stonewood leaders generally shared this intern's views. As one high-ranking official from Stonewood Medical School put it, "Well, I think that the approach that would be most consistent with delivery of high-quality care would be for US allopathic students to only get priority if it's clear that their preparation for residency is superior. Right now, in most cases, I think it is."

There are at least two problems with this perspective, however. First, the very people deciding what constitutes merit are USMDs themselves, like this official. Second, it overlooks the inherent inequalities in the game leading up to residency that systematically favor more-privileged USMDs (see chapters 1 and 2).[8]

Interestingly, very few Legacy residents decried the residency selection process as unmeritocratic (I'll elaborate on this later). Many of them felt that it made sense to prioritize USMDs according to current definitions of merit. Yasmin (IMG, PGY-2, Legacy) explained that certain residency opportunities were closed to her: "You can't come from [the Middle East] . . . and become an ENT [ear, nose, and throat] resident." She then rationalized this by pointing out that US residencies look for different markers of success than what she was used to: "I think it's somewhat unfair. It's fair if you think about the stuff they look for in your CV. I think people coming from my country and the other countries, we are hard workers." She went on to describe her strong clinical skills: "[Where I went to medical school,] we didn't have respiratory therap[ists], like [during] code blues [emergencies].[9] Whoever was there is going to intubate you, so *you better know how to intubate* because you are going to be by yourself intubating" (emphasis added). She noted, however, that these skills did not seem to matter when applying to residency programs: "So we have potential, but then you come here, and you start feeling like, oh my god, this is not even taken into consideration. They look for other stuff. That other stuff is very important, I do realize, because now I feel I need to improve myself in clinical research and those extracurricular activities I need to do."

While Yasmin was frustrated that her previous training was not fully "taken into consideration," she also understood that her CV lacked certain elements, such as research, which made USMDs more attractive. She did mention other strengths, like her intubation skills, but did not dwell on how those strengths were probably more clinically useful in a hospital than, say, having presented a poster at a conference. Instead, she and her colleagues at Legacy internalized the importance of research as a marker of merit in the game in the same way that USMDs did. She felt the game was legitimate in this way.

There were, however, a few non-USMDs who did not believe that residency selection was meritocratic. One was Liam, a Legacy USIMG intern who thought the system was rigged against non-USMDs. He explained that despite having rotated at Johns Hopkins during medical school and having worked there as a researcher prior to that, he knew that a Caribbean graduate like himself would never match there for residency: "There is absolutely no way in hell that Hopkins would ever even touch us *regardless of our numbers* [test scores], and they make that quite clear. Their program says we will not accept international medical graduates. Do not even bother applying or whatever" (emphasis added). When I asked why, he replied simply, "Well, elitist. Elitist, that's why. . . . I helped them publish their work! I reviewed their grants! I knew those doctors! But because of their elitist nature, they don't accept foreign medical graduates." Liam blamed Johns Hopkins for being exclusionary, but he was a notable exception. That so few non-USMDs shared these views, however, is reflective of the extent to which they internalized the belief in meritocracy, which helped legitimate status separation in the profession.

USMDs Are More Deserving

USMDs overwhelmingly expressed their belief that they were not only better qualified for but also more deserving of residency positions than non-USMDs were. After all, the term *merit* comes from the Latin *merere*, which means "to earn" *and* "to deserve."[10] Because of expectations built into the social contract between USMDs and the profession, USMDs felt that they were owed residency positions by virtue of having held up their end of the bargain. They really viewed it as a bargain, and even medical school officials viewed it that way. As one senior official at Stonewood University Medical School put it, "So the argument for [USMDs] getting priority [for residency] is one that relates to sort of the contract between medical schools and medical students. You know, we're charging a lot [in tuition]. . . . So there is this contract: we'll charge you a lot but you'll get something out of it." . . . Most [US] medical students go to medical school thinking the desired outcome here is for me to have the most gratifying career I can have." In exchange for their tuition, as well as years of hard work and deferred gratification, USMDs would come to expect "the most gratifying careers" possible upon graduation—which included top residency positions at places like Stonewood. Program officials (themselves USMDs) espoused a similar logic. When I asked a

Stonewood program official whether USMDs should get priority for residency, they often referred to their own efforts to get into medical school: "The rigor of the kind of application process and what I had to do to get into medical school helped to triage me into getting into an allopathic school, so I would say, for that reason, yes."

Beliefs about USMDs' deservingness were often strengthened by the widely shared—but inaccurate—myth that US graduates would soon outpace the number of available residency positions (see chapter 2 for more on this myth). Residents would point to the growth of allopathic and osteopathic medical schools in the past decade as a reason to be concerned that USMDs would get pushed out of residency positions.[11] Hunter (USMD, PGY-3, Stonewood), for example, explained, "We're seeing more and more that as we graduate more students, we don't have the residency spots for them. And I think there should be some element of a benefit of being someone who trained here, went to school here in the [United States]." Despite increased enrollments, however, the number of US doctors graduating (both Doctors of Medicine [MDs] and Doctors of Osteopathic Medicine [DOs]) is projected to remain well below the number of residency positions in the next decade.[12]

Nevertheless, the fear of running out of residency positions, combined with the belief in the social contract, engendered a shared sense of entitlement among USMDs, who were socialized to believe that because they survived the rigorous and cutthroat process of getting into a US allopathic medical school, they should be prioritized for residency positions. "You're earning your stripes so to speak," as one PGY-2 said. USMDs felt they had held up their end of the deal. In return, they expected the profession to hold up its end of the bargain by guaranteeing them residency positions—and thereby keeping the competition from outsiders at bay.[13] As one Stonewood intern put it, "We're all training with the idea and *we've been told* by our medical school that *we're going to get jobs afterwards* and now all those jobs are going to other people who aren't from the [United States]? . . . [If] all these programs now are only taking people from other countries because they have more experience, *where would that necessarily leave all of us*?" (emphasis added). Notice that merit took a backseat to entitlement in this explanation, with this intern feeling they were owed a residency position even more than someone with more experience.

Importantly, USMDs did not expect just *any* residency position. Most expected access to their *preferred* spots, particularly given the financial constraints they

faced (as I described in chapter 5). When asked, for example, how they would have felt if they had matched into a community program instead of a place like Stonewood for residency after having accumulated all that debt, an intern shrugged and said, "I would be upset . . . because if you worked so hard." A PGY-3 elaborated:

> [It] depend[s] on your idea of what you want to do with your life. Maybe you don't want to see sick people, like really bad cases. [If] they don't want to subspecialize, they just want to do something small, yeah, then community is fine for them. But I think I find working at a tertiary care center also very personally fulfilling. Like there's this thought that somebody is going to die if you're not there, and that's a bit overdramatized . . . but how much of what we do every day can be outsourced? Really, hardly anything, and whereas if you are seeing the bread-and-butter cases in the small community center, there is much more there that can be . . . delegated, and your role is *less unique*. Where if you go through this many years of training and put all your life on hold, *you want to be something special*, and maybe that sounds silly, but that's part of our reality. (emphasis added)

In this way, being "something special" and getting top positions at university hospitals were considered an inherent reward—a status right for having played the game and deferred gratification for so long. Kamens, a sociologist of education, argued in 1977 that "schools symbolically redefine people and make them eligible for membership in societal categories to which specific sets of rights are assigned."[14] USMDs therefore felt that they had been assigned a set of rights associated with their trajectories into US allopathic medical schools. After all, remember that residency went from being considered a privilege to being a "right" for US doctors in the mid-twentieth century, when having an MD was no longer sufficient for practicing medicine.[15]

But also recall that USMDs had considerable help playing the game, yet that help was seldom acknowledged. Instead, the constant emphasis on USMDs' hard work playing the game (as the resident put it, "you go through this many years of training") helped obscure the privileges they received along the way and minimized the considerable efforts put in by non-USMDs, thereby further reinforcing their sense of deservingness compared to non-USMDs.

Another reason why respondents thought that USMDs were more deserving of residency positions than non-USMDs was that they had invested in the

nation's health care system. As Dale (USMD, PGY-3, Stonewood) put it, "You have to accommodate the people that have put money into their education here before you outsource essentially, before you train outside physicians to do the job." Dale readily acknowledged that non-USMDs typically scored higher on standardized tests than USMDs did ("Oh, they're better"), but he felt that USMDs should still be prioritized because they had invested in the system. Here again merit (in the sense of being superior candidates) took a backseat to the deservingness argument.

The converse was also true; some believed that USMDs were more deserving because the system had invested so heavily in them. As Cassandra, a Stonewood intern, explained, "I do think that US students should be given preference. That's where the money is coming from [i.e., the United States]. Those are the people who probably are going to be doctors here." With student loans, subsidized public schooling, infrastructure supports, and the funding of residency positions nationwide by Medicare, the United States does invest considerable resources in training physicians, both US and foreign born.[16] Many respondents, however, were indignant to think about all those resources being spent on IMGs who might just end up going back to their home countries.[17] As Ken, a Stonewood PGY-3 who had immigrated to the United States as a child, put it:

> I think if you are an IMG and you apply to US schools [for residency], there should be some contractual obligation that after you finish your training, you have to spend a minimum of ten years practicing in the United States. Because if you come here and . . . you get a Medicare-funded residency and a fellowship position, you graduate and you get the fuck out of Dodge, that's not right because all of us taxpayers paid for your education that you just then took back to Greece or India.

Here Ken interestingly referred to medicine's social contract with *society* as a justification for prioritizing USMDs.[18] In exchange for the government's investment in their education, the residents offer their work and service to the public. In Ken's opinion, those doctors who could not or would not hold up their end of that bargain were not worthy of support. Some Legacy residents even adopted this view. For example, Trevor (USIMG, PGY-2) understood the preference for USMDs, given the United States' investment in residents: "Obviously you kind of have to take care of your own first, so it would reflect kind of badly on the

[United States] if you're graduating all these US grads but they're not finding spots. And these spots are funded by Medicare I believe, and Medicare is probably funded by our taxes, so it's kind of like there is a social aspect to it too."

Moreover, residents from both programs pointed out that other countries would do the same to retain their own doctors. As one Stonewood intern expressed, "I don't think I would feel upset if I were a US student applying to a foreign country and that country gave preference to their own citizens. I don't think I would feel that was unfair to me." Elliot, another Stonewood intern, put it in terms of a country having an obligation to its citizens who "did all the right things" and were promised success:

> There are a limited amount of positions . . . and for the same reason that I wouldn't expect to go to another country and take a spot that someone who grew up in that country and was part of that culture and has the expectations *that they do all the right things* that they'll be able to succeed in the way that they've been promised they could succeed. So in the same way that I wouldn't expect to go to that country and take a spot from someone who deserves it more than I do from that standpoint, I think it's reasonable for people from this country to not be denied opportunities. . . . You can't screw over your own people, you know? (emphasis added)

For Elliot, the country (or, rather, the profession because the US government is not directly involved in medical training or hiring) has an obligation to its own people who did all the right things—a further nod to the social contract. Most Stonewood residents agreed with this point of view, including those who were involved in global health initiatives and had experience training abroad. One such resident who traveled to Africa on elective said, "I have been that foreign medical grad reversely and it's equally hard. I suck at the system [in Africa]. I should necessarily be lower on the totem pole than the people who are used to that system." She went on to say that a lack of knowledge about the US medical system should also put IMGs lower on the totem pole than USMDs in the United States.

Several IMGs at Legacy sympathized with the US approach because similar processes occurred back home. One Lebanese PGY-1 resident admitted that foreign doctors had a lot of difficulty finding work in Lebanon: "[An] Indian guy who is coming to work in Lebanon as a doctor, [he] will not find a job, not even for a thousand dollars. We won't hire these people. . . . We are already kind of full.

Maybe [if] this guy was trained in the [United States] . . . we will *consider* hiring them, but still is he able to communicate with people? Is he able to be good?" (emphasis in original). Here the intern raised two important points. The first was that about being "full," suggesting that without a shortage of doctors, there would be no need for IMGs. The United States, however, is not full, which makes it reliant on IMGs. The second, however, was that about communication skills, which was a common justification for excluding IMGs from consideration at Stonewood (see chapter 2) and one that I will revisit. In other words, some IMGs shared concerns similar to those of many USMDs about foreigners practicing medicine in their own countries.

To support their views, several Stonewood residents gave examples of acquaintances who went to practice in other countries, like Australia, and who were placed in lower-tier training programs because they were foreign. Yet, unlike in Australia, where internship positions are awarded by priority group (with in-state Australian medical graduates assigned to Priority Group 1, the highest, and non–Australian citizen IMGs assigned to Priority Group 7, the lowest), the residency allocation process in the United States is far less transparent.[19] The US health care system relies on the globalization of medical human resources to staff its nursing departments and residency programs, but unlike in other countries, USMDs get prioritized *without* official policies to that effect, allowing the allocation of positions to operate under the guise of meritocracy. If USMDs were explicitly given priority in The Match, non-USMD applicants' aspirations could be tempered accordingly. Yet only a few USMDs (and virtually no non-USMDs) that I talked to denounced this lack of transparency in residency hiring practices. As one rare dissenting Stonewood resident, himself an immigrant, said, "If they [programs] know that they're just not going to rank them [non-USMDs] high enough to match there, there's really no reason to give them [non-USMDs] the hope or the incentive." He thought residency programs should be up-front about their practices to avoid giving false hope to applicants under a pretense of meritocracy. But such transparency would run counter to the dominant national ethos: the American Dream, which promises that with enough hard work and dedication, anything is possible, including a top residency spot. And as will become clearer, this logic was, in fact, essential for securing consent from non-USMDs for their own subordination.

Taken together, these beliefs about competence and deservingness provided support for elevating USMDs to a higher status within the profession—a position

that even some non-USMDs felt was justified. In particular, the belief about USMDs' deservingness helped reinforce a system in which even the most skilled non-USMDs—the ophthalmologists from Karachi and the orthopedists from Tehran—did not provide real competition for USMDs, who felt they were more deserving of residency positions than even more experienced foreigners because of what they had sacrificed to enter the profession and what the nation had sacrificed to train them. The emphasis was squarely on putting USMDs first, so much so that only a small minority of respondents felt that the current recruitment practices, which seem to favor protectionism more than meritocracy, were not in the profession's best interest. One of these rare detractors was a Stonewood attending who said, "It's not part of the Constitution to . . . be employed as a resident," critiquing the notion that residency should be viewed a right by USMDs. The scarcity of these alternative views, however, speaks to just how widespread beliefs were about USMDs' entitlement to dominance within the profession.

BELIEFS SUPPORTING THE SUBORDINATION OF NON-USMDs

Non-USMDs Are Not as Good

While the beliefs just described served to elevate USMDs' status, a corresponding set of beliefs served to stigmatize non-USMDs as inferior—and thereby more deserving of lower-status positions. In addition to the Stonewood leaders who believed that non-USMDs were risky—because they lacked both medical knowledge and cultural competence (as detailed in chapter 2)—the Stonewood residents openly believed that non-USMDs were lazy and poor communicators. DOs and USIMGs, in particular, were widely perceived as not having worked as hard as USMDs to get into a US allopathic medical school and thus as not deserving the privileges associated with the social contract. As Elliot, (USMD, PGY-1, Stonewood) explained, "[As a USIMG], you're judged by default as being someone who doesn't deserve to be in med school and got in because you're paying a school that's trying to get as much money as it can. . . . The same as DO programs in that respect," referring to the widespread belief that DO and Caribbean schools operate under pay-to-play schemes. Many criticized DOs and USIMGs for not having been good enough to gain admission to US allopathic medical schools. In fact, several Stonewood residents were not admitted on their first try, but this was

seldom discussed openly. Another intern spoke of a friend who went to medical school in Grenada: "He did not work as hard in college, which is why he didn't get into medical school, but he is probably every bit as smart as I am. Yeah, they [USIMGs] still have to take all the same tests, and a lot of times I'm sure they are a lot better [than USMDs] because they have a lot more to lose." Hard work was thus a critical aspect of merit—at least as important as intelligence for this intern. After all, IQ plus *effort* is thought to equal merit in a classic meritocracy.[20]

For their part, while most IMGs were praised for being very smart, they were almost uniformly criticized for lacking the cultural tools to adequately practice medicine in the United States—just as Stonewood program officials maintained in chapter 2. As Vivek (USMD, PGY-2, Stonewood), himself a first-generation immigrant, confided, "[When] I get something from a physician who I know has been trained abroad, I don't know what is going on with the patient. . . . They're brilliant; I ask them a medical question, [and they] know the answer right away. . . . But there's two parts to being a doctor," referring to knowledge and communication, which he had mentioned earlier in the conversation. Others made sweeping inferences about IMGs by referring to only a few individuals. For example, one intern said, "[IMGs] don't treat pain. A few people here that I have met are way less concerned about treating pain in procedures and stuff because they don't do that at home, so they just don't think to do it here."[21] As I will discuss later, this tendency to generalize may stem from the fact that Stonewood residents had only limited exposure to IMGs.

In addition to being characterized as lazy and culturally incompetent—and thus deserving lower-status residency positions in community hospitals—non-USMDs were stigmatized for training in those very community programs, which Stonewood residents widely viewed as less rigorous. These beliefs helped support the analogy of the dichotomy between the Navy SEALs and the National Guard introduced at the beginning of this chapter. Importantly, Stonewood residents rotated at three hospitals, two of which were community-based medical centers (only Stonewood was a tertiary university hospital), and some of them even felt that the ward rotations at the community hospitals were more challenging than the ones at Stonewood's flagship hospital were.

Still, negative perceptions of community-trained doctors abounded, to the point where some residents openly questioned their competence. After admitting that he would not want to be a patient at a community hospital—a sentiment widely shared by Stonewood residents—Logan, a PGY-2, said, "I'm not saying

they're killing people over there or anything, [but], yeah, there's a lot of shitty doctors out there. I don't think people realize that there's a lot of shitty doctors out; we see it all the time. We get transfers from other [community] hospitals, and, you know, I'm a second-year resident and I can be like, this is ridiculous." Similarly, Gunther, a PGY-3, relayed a story about a friend in a community program: "They had a patient that came in with DKA [diabetic ketoacidosis] who died on the floor [wards].[22] . . . A patient shouldn't die from DKA. He was like thirty or something—a young person. But I just worry about what kind of training she's getting over there because I talk to her about stories, and she doesn't really, she doesn't get taught, [and] they work her like a dog, and I don't know if she's getting anything out of it." When I asked about the implications of having tiered residency programs, he replied, "I think it matters for the patients that you're going to care for." This resident felt that stratification within the profession could have alarming consequences for patient care. Similarly, Lynn, an intern, advised her father who had suffered a stroke to avoid his local community hospital: "Especially with time-sensitive things, like a stroke, where you can qualify for tPA,[23] I don't want any idiot who doesn't know what the window is for tPA greeting my dad at the door reading the wrong article that says it's a three-hour window as opposed to the new article that says it's safe to do it in four and a half hours. He didn't read that. I don't want that to be the difference between my dad using his hand again, you know what I mean?"

To be sure, some of these concerns are consistent with the findings in chapters 3 and 4 that there were considerable inequalities in training between Legacy and Stonewood residents. However, they also represent an important conceptual challenge to the presumed gap-filling function of non-USMDs in community hospitals; if their training is so poor, it could be hazardous to allow them to practice, creating a crisis for a profession that cannot staff all of those positions.

Perhaps for this reason, most respondents toed a fine line between believing that non-USMDs were less qualified than USMDs and believing that non-USMDs were dangerous: "They're probably trained enough, but I wouldn't say they're as well trained. I don't know," demurred one PGY-3 resident, echoing the same rhetoric used by Stonewood officials when pressed on the implications of pooling "risky" non-USMDs in community programs (see chapter 2). This professional doublethink ("not as good but good enough") came up during an interview with Dr. Taylor, one of the few non-USMDs on the faculty at Stonewood whom I introduced in the previous chapter. Despite having received a lot of pushback from the

hospital leadership because of their pedigree, with one particular official even threatening to block their promotion simply because they were a non-USMD, Dr. Taylor was still considered one of the best doctors at Stonewood, and this sometimes led to awkward encounters: "The irony was . . . I remember being called down at least once to see one of this [official's] family members, being paged to come in." While this well-respected attending's pedigree was problematic from an institutional perspective, it did not seem to stop this official from paging Dr. Taylor directly to care for a family member who was sick. When I asked Dr. Taylor how they made sense of that, they shrugged and said with a laugh, "I think it's fascinating. You can't. And, obviously this individual, I think he had abject prejudice."

The truth was that Stonewood housestaff spent very little time working with non-USMDs, so their negative views were often based on limited knowledge or experience. One exception was at Tri-Hospital, where Stonewood residents spent at least two months rotating alongside non-USMD residents from nearby Solomon Community Hospital. At Tri-Hospital, patients were taken care of by four teams of residents: the red, white, and blue teams, which were composed of Stonewood residents, and the yellow team, which was composed of Solomon residents. The symbolism of these team labels could not have been more poignant—at once a nationalist nod to USMDs from Stonewood and a racist reference to the IMG housestaff at Solomon. A Stonewood intern who had yet to rotate at Tri-Hospital expressed surprise when she learned that the red, white, and blue teams were from Stonewood while the Solomon team was yellow. "What? No way, you have got to be kidding me!" Another intern replied innocently, "What? It's just a color. It's like this is a yellow room." The first intern repeated, "Red, white, blue, [and] yellow. Seriously?" The second replied, "One is the color of the flag, the other one is . . . [*trailing off*]." Yet another asked, "Would it be better if they were the *red* team?"

It was common for Stonewood residents to make fun of the yellow team. As Jerry (USMD, PGY-3, Stonewood) explained, "The majority of the residents here definitely kind of look down on [the yellow team]. . . . There's definitely a lot of snickering and condescension I think." Stonewood residents consistently complained that patient handoffs from the yellow team were sloppy—even though all four teams at Tri-Hospital were overseen by the same set of attendings, including a common chief resident from Stonewood. As Barbara, another PGY-3, relayed:

> At [Tri-Hospital] we work with [Solomon] residents, and . . . we'll say, "Oh, who was on call today? Oh, it was the yellow team," and we know the yellow

> team is [the Solomon] team. If something goes wrong, it's like, "Oh, well, you know who was taking care of them." Or "Oh, obviously I didn't get a good sign-out because you know who it was." So that's definitely pervasive.

This perspective may have partly stemmed from the fact that Stonewood residents never actually worked on the same team with non-USMDs—they worked *alongside* the yellow team but in their own teams. In this way, segregation may have helped fuel stigmatization by making it easier to attribute negative outcomes to the lesser known other.[24]

In fact, those respondents who spent more time working with non-USMDs (outside of Tri-Hospital) tended to have a better perception of them. An Ivy League–trained preliminary USMD intern at Legacy admitted, for example, "For whatever reason, people don't think that those people who go to those schools are—I don't know if they don't think they are as smart or as prepared or whatever, [but] that's like the reputation. I have worked here [at Legacy] with pretty much all people that fit the category and I don't think that that's true, but *you don't really know unless you work with them*" (emphasis added). A PGY-2 Stonewood resident also conceded that his negative impressions of DOs had changed when he finally worked with them: "I had a lot of personal biases. I didn't think DOs were as good as MDs because I had never even heard of it until I was probably in medical school. . . . [During my rotations], most of the residents were DOs, and they were some of the best residents that I have worked with, some of the best mentors I have ever had. . . . I had thought they weren't as well trained, [when], in fact. they were better trained." If Stonewood residents had had more experience working with non-USMDs, their views of them might have been more positive, thereby helping attenuate status distinctions between USMDs and non-USMDs.

A few Stonewood residents acknowledged that these status distinctions were arbitrary or even "silly," as one resident put it. Several noted how distinctions boil down to minutiae—or minor details used to differentiate between equivalents.[25] One PGY-3 rolled his eyes and said, "I mean it's not like we're giving people antibiotics at this hospital and Solomon Hospital is telling them to take this root or herb to eat. You know we both have penicillin, we both have CT scans," suggesting that differences between university and community hospital trainees were likely overblown. Similarly, as Lorna (USMD, PGY-3, Stonewood) remarked about status differences between community and university programs, "I don't know, it's really weird. . . . I think everybody actually knows that it's kind of this

nonthing that exists. . . . It's not actually a difference; it's just how things kind of polarize." Differences between USMDs and non-USMDs may have therefore been amplified to justify relegating non-USMDs to less desirable positions—not unlike how Stonewood officials justified excluding non-USMDs from the program's Match list in chapter 2—even though many believed that such differences were not hugely meaningful in practice.

Others went so far as to suggest that differences between USMDs and non-USMDs were completely made up. Elliot, a Stonewood intern, put it rather bluntly: "I mean, there's no way around it: there are [non-USMD] students that are trained in an identical manner [to USMDs], that have the same potential, who are not allowed access to certain [residency] programs—that's sort of the definition of discrimination, you know?" Elliot's comment underlines an important reality: while the distinctions may have been (at least partly) artificial, they still had real implications for inequality.[26] Presumed differences between USMDs and non-USMDs, however arbitrary, were widely internalized as socially valid—and thus broadly influenced social behavior within the profession.[27] For example, Collette, a Stonewood intern who rotated at a hospital with non-USMD residents during medical school, described the mixed perception of those residents among her fellow medical students:

> It's so hard to explain. So I think everybody thought they were very good and were good teachers for the most part. One of the best teachers, she won the teaching award, was a Caribbean grad. . . . But the perception [among US medical students] is still, "I want to go to a place [for residency] where there is mostly US grads." . . . I don't know how to explain it other than just bias of "Oh, you went to a Caribbean school; there must be something that you couldn't get into US schools." . . . I guess, I don't know, that was my, all of my perceptions about them.

Despite having had very positive experiences with non-USMDs in medical school and seeing how competent they were, this intern still chose a residency program with mostly USMDs. Even though *her* perceptions of non-USMDs may have been positive, she knew that not everyone shared her view and that professional status is powerfully constructed around these negative assumptions. Put differently, she acted in accordance with those assumptions, making the beliefs real in their consequences. Her experience speaks to how ingrained the stigma

has become, such that regardless of their performance or skills, non-USMDs will likely remain in subordinate positions because more powerful USMDs *believe* they belong there. As one rather perspicacious Stonewood intern pointed out, "[Medicine] has a culture of institutionalized perceptions about things that nobody's immune to."

Furthermore, these "institutionalized perceptions" were long-standing and regularly reinforced throughout USMDs' training, making them difficult to change. One preliminary intern at Legacy who went to an elite USMD school admitted how surprised they were at their non-USMD colleagues' competence, given how they were socialized to think negatively about them:[28] "It might sound like I'm an asshole and I really don't mean to, but I was surprised at how much a lot of them knew because I did think that I was going to know a lot more than everyone because of my background." USMD students and residents were repeatedly taught by peers and superiors—almost always informally—to believe that non-USMDs (and, by extension, the community programs staffing them) were second-rate. A Stonewood attending reflected, "I think *we tell ourselves* there is more variability at the other [at community hospitals], although ultimately we all have to pass the same Boards, right, to practice? . . . All I can say is I know we think that [about community hospitals], and I know that we kind of talk about that." Thus, whether or not USMDs were actually superior to non-USMDs was in some ways immaterial—what mattered was that USMDs (who held elite positions in the profession) *believed* they were.

Thus, arbitrary or not, USMDs systematically benefited from the social importance attached to the stigmatizing of non-USMDs because it helped make USMDs superior. As one Stonewood USMD intern thought aloud one day:

> I just wonder overall if this whole issue is related to the [fact that] people who govern or who hold the power in medicine don't want to give that power up and they've always had it. So it's not necessarily [a matter of] do international grads deserve spots? It's not about that. That decision was made a long, long time ago, and now the people who benefit from it, like us, grew up in the [United States], went to school here, we know we have job security. *Why would we want to give that up, right?* . . . Once you have that advantage, I think it's really hard to get people to say someone's got to give. It's not going to be me: I'm in debt, I deserve a spot, I worked hard. So it's going to take some outside governing body to say this is how it should be. (emphasis added)

USMDs therefore gained considerable advantage from attributing lower status to non-USMDs—an advantage they were not likely to give up easily. Bolton and Muzio used a similar argument to explain gender inequality within the legal profession: "Gendered segmentation, which thrives on the ideology of women's difference, has become a defence mechanism of an embattled profession, ensuring that the elite segments can, in the context of a more hostile institutional environment, hold on to their traditional privileges and rewards."[29] Thus, even if the ideology of difference is sometimes based on thin evidence and arbitrary distinctions, the *benefits* it yields are invaluable to those who seek to protect their advantages, consciously or not.

CONSENTING TO SUBORDINATION

It makes sense that USMDs would espouse status beliefs that serve to elevate their own professional esteem. But I also found that many non-USMDs agreed with the beliefs I have discussed, particularly that the United States should prioritize its own graduates. These findings suggest that non-USMDs have come to embrace some of the very principles that lead to their own subordination. In fact, very few non-USMDs deplored the current system, in which the more elite segments of the profession cast them as second-rate. Only a handful of respondents at Legacy expressed outrage at the fact that they were systematically excluded from certain opportunities. One was Liam, the Caribbean graduate mentioned earlier who was angry at Johns Hopkins. Another was Faisal, an IMG who had already completed residency training in his home country before coming to the United States: "I was shocked. Because you heard always that [the United States] is a 'freedom country.' . . . Where's that freedom they are speaking about? I have said always, just give me a chance. Like just give me a chance to see me, test me, and then make a decision and [do] not say no just because I'm a foreigner. . . . They don't give you the chance to even go for an interview." Those who expressed such views, however, were definitely in the minority.

While the status beliefs described in the first part of the chapter are essential to the reproduction of USMD dominance, so is securing the implicit consent of those doctors being subordinated. After all, if non-USMDs refused to accept USMD dominance, the profession could face a serious revolt from non-USMDs

demanding equal treatment for equal credentials (not unlike the deep split predicted by Freidson between the formal elite and the rank and file).[30] No such revolt has happened, however. Instead, as I have noted, many non-USMDs willingly took on lower-status positions in the profession. So why would trained professionals consent to such status subordination?

Belief in Hard Work (and Its Corollary, Self-Blame)

Non-USMDs consent to subordination in part because of their steadfast belief in the value of hard work and dedication. Despite being aware of the barriers associated with being non-USMDs, we have already seen how Legacy residents strongly believed that if they worked hard, they could overcome the stigma associated with their pedigree and be seen for their true worth. The emphasis on individual effort or agency, rather than on "circumstances of life," and the accompanying "belief in success among the unsuccessful" have long been major tenets of American managerial ideology—and the American Dream, more broadly.[31] I argue that this belief in agency helped legitimate the current social order in medicine, as it gave at least *the impression* that ascension to the elite was possible.[32]

Harvey (USIMG, PGY-2, Legacy) was a good example. Before accepting an offer from an offshore medical school, he asked alumni from that school about the prospects for residency. They told him:

> As long as you work hard, as long as you finish in the top half of your class, you're going to get a residency. Whether or not you get a *competitive* one, you know, that depends on how hard you work because obviously you're not going to get . . . like the chance of you getting dermatology or orthopedic surgery coming from [the Caribbean]? Doesn't look good. So you know, but *if you really want it, nothing is impossible*. (emphasis added)

Harvey's interaction with alumni is an example of how the belief in hard work and dedication can reproduce itself through peer networks. Legacy leaders also reinforced this belief when it came to fellowship applications. Recall how one internationally trained official said Legacy residents could match into any subspecialty, including highly competitive ones like cardiology: "So it's not like you can't; there is no can't; *it's just how much work you have to put into it. Do you really want it?*" (emphasis added).

Yet, when the belief in hard work is juxtaposed with the reality on the ground, it becomes apparent how misguided that belief was. No one matched into cardiology from Legacy, despite the official's optimism. And recall, for example, that when I asked a Stonewood official about the chances of *any* Caribbean graduate matching to Stonewood's internal medicine program, they replied, "Probably as close to zero as you can get. I don't even know if we've ever even interviewed someone" (see chapter 2). Stonewood did not openly advertise this position, however, so the lack of transparency in the residency selection process only helped stoke beliefs in a meritocratic process where hard work could unlock all doors.

The corollary to that belief, however, is that if non-USMDs did not attain their goals, it was because they did not work hard enough. This shared thinking led to a lot of self-blame, as we saw in chapter 1, particularly among USIMGs, many of whom took personal responsibility for their limited career options, despite facing severe structural constraints and harder work conditions than USMDs did. When describing his prospects for fellowship, Adrian (USIMG, PGY-2, Legacy) said:

> I want my fellowship program to be better than my residency. I want to improve on what I do. I got a late start in life and I procrastinated a lot. . . . *Can't blame anybody if you're in a shitty place*. . . . It's where you put yourself, and if what I've done in the past limits me, then I have to accept that. It sucks; it's hard not to look back and kind of kick yourself 'cause you knew if you did something better, you'd be in a better spot. (emphasis added)

Adrian and others would emphasize agency in this way, blaming themselves for their positions rather than explaining their struggles as a result of structural inequalities, like the fact that Adrian was the first to go to college in his family and had less support than most USMDs. The difference between Adrian and USMDs wasn't the *capacity* or even the desire to work—rather, it was that he lacked the blueprint for success that came with being born into privilege.

Harvey was in a similar position. About half an hour after he told me, "If you really want it, nothing is impossible," he admitted, "I was stupid. If I had to do it over again . . . but, no, I mean it was my own fault; I screwed up in college. I should have studied a little bit more. . . . I wish there was someone there like kind of like giving advice. I would tell my younger self like, 'Do this; do this instead.' " His comments are powerful; by overemphasizing his role in going to

the Caribbean, he obscured the structural obstacles (such as a lack of guidance), which he mentioned only in passing. In this case, lacking the early life and college support to get into a US medical school, Harvey and others (including many USMDs, as described earlier) viewed going to the Caribbean as a personal failure rather than (at least partly) the result of structural barriers.

These findings echo earlier work on medical education and the medical profession, which highlights how career trajectories are often believed to be the direct result of one's own decision-making.[33] Bourdieu and others have also written extensively about how educational institutions can produce a *habitus* that leads individuals to internalize the social order as legitimate (despite obvious structural inequality), which can help explain why non-USMDs were so quick to blame themselves for their struggles rather than a rigged system.[34] As Jewel has noted about American legal education, for example, "The myth of merit creates a habitus that causes law students to internally arrive at individual expectations and goals based on the legal profession's existing hierarchy. Through this process of objectification, students come to believe that status within the law profession is not arbitrary, but is instead based on principles of individual merit and intelligence."[35] Jewel goes even further to argue that such a habitus is more efficient than physical coercion at getting "the dominated to complicitly participate in their own domination," thereby making it a powerful tool for securing consent among the subordinated.[36]

Social psychologists also agree that for status beliefs to be effective, people in *both* the advantaged and the disadvantaged groups must agree (or at least concede) that people in the advantaged group are "better," despite the strong tendency toward in-group preference.[37] Thus, it is perhaps unsurprising that some Caribbean graduates felt they deserved to have a lower status compared to USMDs. For example, Allan (USIMG, PGY-2, Legacy) admitted, "Yes, the stigma is there [for Caribbean grads], and I think it's fair because the US graduate,, for whatever they've done, they have proven themselves; they've overcome that obstacle already of getting to medical school. The Caribbean grads have not, so they have to get into residency, and then after that, I think it's all fair [equal] again." Interestingly, he felt that professional status normalized among USMDs and non-USMDs once they entered residency, even though the data presented in chapter 5 show otherwise. By finding the logic fair—or, at the very least, understandable—non-USMDs acquiesced to being considered inferior to USMDs, thereby helping perpetuate their status subordination within the profession.

The Reserve Labor Army

Internalized beliefs about merit are not the only reason why non-USMDs consented to take on lower-status positions in the profession. They also had to contend with more practical concerns. One such concern was the realization that they were among the lucky few who made it. As Kamal (IMG, Legacy) put it, "It's not an easy situation to get into residency in the [United States]." Similarly, when I asked Rashad, an intern from the Middle East, how he felt about being one of the IMGs who, in his words, were "filling the gap" in the United States, he replied, "It doesn't bother me because there [are] already thousands of people who want to be filling this gap, and they were not able to get here. So the point is I am not looking at it as in, they took me because they were not able to [get] anyone [else]. No, no, I'm good compared to my friends; everyone knows how good I am. I'm happy." This intern was a willing participant because he knew how hard it was to get a spot. He went on: "I mean for us [IMGs] being here by itself; I'm not complaining, it's an accomplishment; I'm just fine, I'm happy. I'm not like, ah shit! I ended up here. No, that's not the point. Being able to come here by myself, it is an achievement." Remarkably, as others have found with (unskilled) migrants, internationally trained physicians like Kamal and Rashad were willing to take jobs that Americans viewed as undesirable partly because they knew that they were quite fortunate compared to their compatriots back home.[38]

Indeed, several Legacy residents—including a few who were US citizens—expressed gratitude for simply being able to practice medicine in the United States. Some recounted stories about friends they knew who were not able to match; for example, Trevor, a USIMG, said, "I have heard a lot of horror stories; I have a friend that had double 99s [percentiles on his US Medical Licensing Examination], applied to internal medicine. He didn't match actually." When asked how he felt about having restricted opportunities for residency, Mathias, a Canadian resident who studied in the Caribbean, replied, "I mean I think that's fair. . . . It would have been really, really hard for me to become an MD in Canada . . . so I'm thankful that this opportunity is here, and I think it's fair because I guess there [are] more residency spots than there are med students. So they can fill the gaps in that way." This intern had no objection to being one of the physicians filling those gaps because he likely would have otherwise been unable to continue his training in his home country. Georgina (another Caribbean graduate), who initially aspired to become a surgeon, said, "I'm just

happy to be a doctor. And I changed my mind; I wanted to be a surgeon and I think if I really had tried, I could have done it, but now I'm happy being where I am, so I'm okay with it. I think the system is kind of the way it is, and I don't think it's going to change anytime soon. I think it's actually getting harder for foreign medical graduates, so for me I'm relieved I'm already in a spot." Georgina was glad to be part of the active labor force instead of part of the thousands in the large "reserve army" of unmatched applicants eager to take her place.[39] Like other historically marginalized workers, including women in male-dominated professions, non-USMDs understood that they ranked lower in the labor queue and filled positions only when the supply of more desirable workers (namely, USMDs) had been depleted.[40] In other words, non-USMDs were conscious that they benefited from the shortage of USMDs while also being acutely aware that up to half of all non-USMD residency applicants did not match.[41]

Residency Ready Physicians, a national Facebook group with more than five hundred members, reveals just how lucky these residents were. As Dr. Neviana Dimova, a Bulgarian-trained US citizen, wrote on behalf of the group, "According to the latest statistics, there may be as many as 6,000 U.S. citizens and permanent resident IMGs (International Medical Graduates) who have not been able to enter the required residency training. We want to work and are ready to serve where needed. We would consider it a privilege to work in a rural or inner-city area, just knowing that we have the opportunity to use our skills to help people."[42] Status pain—of the kind Bosk described among the "mop-up" genetic counselors—never materialized at Legacy because most non-USMDs had firsthand knowledge of how lucky they were to make it to front of the line compared to many of their colleagues who had not.

Pragmatic Acceptance

Some Legacy residents thought the system was unfair but felt resigned to accept things the way they were. As Allan, a Legacy PGY-2, explained, when he told attendings during clerkships that he went to a Caribbean school, "They automatically say you're at a disadvantage. And they know the system, that's how it is. It's not going to change anytime soon." This kind of "pragmatic acceptance" thus further allows for cohesion, rather than conflict, within the profession.[43] Mann studied social cohesion in liberal democracies and found that value consensus among societal strata is less important than *pragmatic* acceptance by subordinate

classes of their limited roles in society. Similarly, Ridgeway and Correll found that people tend to accept negative beliefs about themselves, if only to manage the behavior and judgments of others, often resulting in a kind of self-fulfilling prophecy.[44] In this way, as long as non-USMDs accepted their treatment within the profession, even if they disagreed with USMD dominance, their subordination continued unfettered.

Ashley, an osteopathic medical student at Legacy with aspirations of becoming an orthopedic surgeon, espoused this pragmatic acceptance. She knew that despite having completed an excellent "audition rotation" in orthopedics prior to applying for residency, she would struggle to match because of her pedigree as a DO. When I asked her how she felt about that, she replied by telling me about her previous failed attempts at getting into an allopathic school: "Having that experience very early on of, like, "*Hey Sugar, this is life*," [helped]. It's all about scores; there are way too many applicants for the number of spots and that's just how it is and deal with it; you're not going to be able to change it. . . . So I think now when I think about [how] it's going to happen again probably . . . it's not new to me because it's something I'm already over" (emphasis added). For this DO student, having lived through perceived injustices when applying to medical school helped condition her to accept unequal treatment later in her career.

Others felt it was just easier to be "at peace" with oneself and accept the current opportunity structure than to fight against it. Remember Trevor, the USIMG who went to medical school in Southeast Asia and used the term *foreigner* to refer to himself even though he was a US citizen. Trevor described the current situation for foreign-trained doctors like himself: "Foreigners are coming into the US system . . . so whether it's fair or not, like I said, it's inconsequential; you just have to play by the rules basically." Trevor's reference to himself as a foreigner speaks to just how internalized status distinctions along pedigree lines have become within the profession. He also felt compelled to accept his subordinate status as a foreigner if he wanted to be happy: "If you didn't know that coming into it, then it's almost like you were a little naïve and you didn't do your homework. So I think if you're aware of it and what to expect, I think it's a lot easier to be at peace with yourself instead of being grumpy about what could have been or wish it was more fair, wish I had the same opportunities."

Trevor raised an important point about being previously aware of how the system works. As I indicated in chapter 1, Legacy residents knew that they would face more limited opportunity when applying for residency; for example,

one intern (a former surgeon in his home country) noted, "I knew that coming into this. I came into the whole thing with my eyes open." This perspective likely helped him feel more comfortable with having to start over as an intern after having completed residency in his home country. He was fully aware of the pitfalls, but his desire to practice medicine in the United States was stronger than whatever barriers he would face. In contrast, only a few others (like Faisal, the outraged resident I quoted earlier) had different expectations of the United States, thinking it was a land of opportunity and not expecting discrimination.

Lack of a Unified Perspective

A final possible reason why non-USMDs did not resist their own subordination is that they lacked a unified perspective. This was not for lack of opportunity, however. Segregation in residency programs actually offered the potential for a united front because non-USMDs were kept separate from USMDs. Legacy residents had access to "relational spaces," like the residents' lounge, which served as areas where they could discuss opinions and form a collective position away from superiors.[45] However, during the hundreds of hours I spent with them, they almost never discussed their status vis-à-vis USMDs, even though they would frequently discuss other injustices, such as the poor teaching at Legacy or Medicare cutbacks.

The diversity of the housestaff at Legacy may have been one factor preventing the formation of a united perspective. About half the residents had young families, which meant they spent less time socializing with those who did not have children. Age differences were also quite important, with some residents as young as twenty-five and others as old as forty-two, which meant they were in quite different stages of life. Cultural differences were perhaps the biggest barrier to unity. While almost every single resident expressed appreciation for working with such a varied housestaff, there were still visible distinctions between US and non-US residents. English, French, Spanish, and Arabic could be overheard simultaneously at any given time in the residents' lounge, and even though everyone got along, sometimes cultural references would be lost on those who were not from the United States. The US residents also sometimes teased the non-US residents, making fun of their accents or pronunciation. One day, for example, while playing a video game, a resident from Southeast Asia exclaimed, "He's malingaling!" referring to his avatar on the screen who just got injured. The other (US-born) residents began to laugh uncontrollably at the resident's attempt to

say *malingering*. "Malingaling?" one of them mocked jokingly. This comment elicited good-natured laughter from everyone in the lounge, including the Southeast Asian resident, suggesting that the housestaff actually got along well enough to poke fun at one another. That said, the diversity of the housestaff likely made it more difficult for them to form a unified perspective to challenge their subordinate status within the profession.

Also, not all non-USMDs had the same perspective on the issue of their place in the profession, making it more difficult for them to join forces and create a unified front. IMGs' experiences, for example, were quite different from those of US citizens who studied in osteopathic or Caribbean medical schools. For some IMGs, being a lower-status doctor in the United States was better than being a high-status doctor in their home countries. As one IMG shared, "The [United States] is giving you opportunities to live a better life." In contrast, some USIMGs felt they should be prioritized over IMGs because of their citizenship status, and some DOs and USIMGs heavily criticized IMGs' cultural and language skills. They were all underdogs—but for different reasons. This meant it was more difficult to relate to one another and form alliances for collective action.

CONCLUSION

In sum, there is a widely shared and complex belief system supporting status distinctions between USMDs and non-USMDs in internal medicine. USMDs were generally believed to be more meritorious than other graduates; thus, they were granted rightful access to elite positions within the profession under a presumption of meritocracy. Perceptions of merit, however, were strongly influenced by powerful expectations cultivated through a shared belief in a professional social contract that nearly guaranteed certain privileges as *rights* to USMDs. Meanwhile, non-USMDs were subordinated in status and stigmatized through the reification of sometimes arbitrary distinctions that served to protect the prestige of US medical graduates.

Non-USMDs, in turn, consented to this lower status either because they counted themselves lucky to be part of the active labor force or because they bought into the ideology that finds USMDs more meritorious to one degree or another. In fact, USMDs at Stonewood were more likely to point out injustices in the system than were the non-USMDs at Legacy. Put together, these beliefs make

it possible for non-USMDs to serve at the pleasure of USMDs, who rely on them to support USMDs' elite status and fill the positions they do not want to fill.

These findings support the theories of social psychologists who find shared status beliefs to be critical to the creation and maintenance of stratification because of the presupposed link between status and competence.[46] They also confirm the worst fears of Young, a British sociologist who published a satirical but cautionary monograph entitled *The Rise of the Meritocracy* in 1958. Referring to the book, Karabel notes:

> Perhaps worst of all, from Young's perspective, was the effect that meritocratic competition had on winners and losers alike. In the meritocracy, Young writes, "the upper classes are . . . no longer weakened by self-doubt and self-criticism," for "the eminent know that success is just reward for their own capacity, for their own efforts, and for their undeniable achievement. . . . As for the lower classes," they "know that they have had every chance" and have little choice but to recognize that their inferior status is due not as in the past to denial of opportunity, but to their own deficiencies.[47]

While Karabel was concerned with admission to elite colleges and Young was referring to a futuristic dystopian society, they might as well have been writing about the modern US medical profession. The myth of meritocracy in medicine, which emphasizes effort and achievement over structural inequality, helps grease the wheels of status separation between USMDs and non-USMDs, creating an entitled upper class of Navy SEALs and a humble underclass of National Guard members within the same specialty.