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Institutional legacies, employment and professional integration of non-EU/EEA doctors in France

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Abstract

Internationally, policies for attracting highly-skilled migrants have become the guidelines mainly used by the Organisation for Economic Co-operation and Development (OECD) countries. Governments are implementing specific procedures to capture and facilitate their mobility. However, all professions are not equal when it comes to welcoming highly-skilled migrants. The medical profession, as a protective market, is one of these. Taking the case of non-EU/EEA doctors in France, this paper shows that the medical profession defined as the closed labour market, remains the most controversial in terms of professional integration of migrants, protectionist barriers to migrant competition and challenge of medical shortage. Based on the path-dependency approach, this paper argues that non-EU/EEA doctors' issues in France derive from a complex historical process of interaction between standards settled in the past, particularly the historical power of medical corporatism, the unexpected long-term effects of French hospital reforms of 1958, and budgetary pressures. Theoretically, this paper shows two significant findings. Firstly, the French medical system has undergone a series of transformations unthinkable in the strict sense of a path-dependence 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. Secondly, there is no change of the overall paradigm: significantly, the recruitment policies of non-EU/EEA doctors continue to highlight the imprint of the past and reveal a significant persistence of prejudices. Non-EU/EEA doctors are not considered legitimate doctors even if they have the qualifications of physicians which are legitimate in their country and which can be recognised in other receiving countries.

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Contents

1 Introduction

Policies that attract highly-skilled migrants have been increasingly promoted within the Organisation for Economic Co-operation and Development (OECD) countries (OECD 2008; Czaika and Parsons forthcoming; Czaika and Toma 2015; Parsons forthcoming) with governments implementing specific procedures to attract and facilitate their mobility (Toma and Villares-Varela forthcoming). However professions are not treated equally when it comes to welcoming highly-skilled migrants (Czaika and de Haas 2013, 2014). The medical profession as a protected market is one example: in the United States (US), Brenton et al. (2013:1) show how the establishment of occupational licensing regulations works 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 definite period of training time (Mendy 2014). France is another example, where doctors with a non-EU/EEA degree have a status with less professional prerogatives. The employment and professional integration of migrant doctors with non-EU/EEA degrees called *Praticiens à diplôme hors Union Européenne (PADHUE)* is the subject of ongoing debate. They are tolerated but not fully accepted within the medical profession and hired to fill medical shortages in specialities and locations where French doctors do not want to practice. The situation in France does not reflect the optimistic discourse surrounding the international mobility of highly-skilled migrants.

The origin of this conflict can be traced back to the French 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 arrived for professional or academic reasons and remained in France once their initial official reasons for staying concluded and work in France under the conditions fixed by the French Code of Public Health and secondly, those who studied medicine in France[1]. For these first two categories, migrants are supposed to return to their countries of origin once their study or specialisation is finished. 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 limited rights as a doctor. Finally, those who failed the PAE represent the third category. A doctor with a non-EU/EEA degree faces a status with limited medical privileges and professional constraints, which are exacerbated by unequal working conditions. Despite occupying a large number of positions and contributing to the functioning of public hospitals (Cash and Ulmann 2008; Cottereau 2012; Cnom 2013) their status and salary are lower than doctors with French or EU/EEA certification. Within the academic community the only point of consensus as to why this is the case is the complexity and puzzling nature of this issue (Deplaude 2009, 2011; Coufinhal and Mousquès 2001; Le Breton Levillois 2007; Moullan 2014), however some authors have put forward a few different explanations.

Danièle Lochak (1995), Professor of Administrative Law and Chair of the Information and Support of Immigrants Group argues it is the complexity of hospital law in France which creates this

[1] Although not the same curriculum as French students as they are accepted within the eight per cent quota dedicated to foreign students in medicine, while French students are selected through the *numerus clausus* examination. Only students whose score equal to or better than French students at the bottom of the required ranking are successful candidates (Cash and Ulmann 2008:55).

[2] The *Procedure 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.

series of conflicting imperatives, whereas others argue it is discrimination, whether legal (Berland 2006; Deplaude 2009, 2011) or hidden (see further, post-colonial study authors: Mbembe 2005a: 143; Blanchard et al. 2005). Based on the path-dependency approach (David 1985; Pierson 1996), which attaches great importance to historical factors as key explanations, path-dependency theorists would argue 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 in 1958 and 1980s, coupled with budgetary pressures.

After presenting the theoretical framework this paper will review the three key explanations mentioned previously to better understand the issues which restrict non-EU/EEA doctors from professionally integrating in French hospitals. Finally, I conclude that EU enlargement tends more and more to restrict the employment places available to non-EU/EEA doctors in French hospitals which results in their marginalisation.

2 Methodology

This article is based on the results of research focused on the international migration of doctors with African degrees in the United Kingdom (UK), France and Switzerland (Mendy 2010). The research this paper utilises is from data gathered during the French case study (Paris, 2006). The case study involved 15 semi-structured interviews with doctors with African degrees, an interview with the union of doctors with non-EU/EEA degrees and an interview with 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) those who did their medical studies in France - selected from a quota of eight per cent; (2) those who carried out part of their training in Africa but completed and qualified in France, and finally (3) those who graduated in medicine from an African university and obtained the title of doctor with the right to practice medicine in their country of origin. Their ages ranged from 34 to 56 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 the scientific and legal literature was conducted and we analysed discussion forums after the publication of press articles, in newspapers and on the websites of television magazines that highlighted France's use of doctors with foreign degrees.[3] The 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 their statements confirmed the results of our interviews and the literature review. From a scientific point of view, an

[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 qualified as 'second-rate practitioners.' The second article is published by TF1 News. '*Swirls on the free installation of foreign doctors'* February 12, 2009, which gives an account of the reactions of the votes 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 TF1 said that he is concerned by the cases of foreign doctors 'completing' only their basic training, which in comparison to a French degree, he considers 'insufficient'. The third article published by the newspaper Liberation, '*Foreign doctors: We are exploited and thrown away*' March 4, 2009. It follows the 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'.

important point to consider in the analysis of blogs or readers' mails to be analysed as empirical material is to understand the context in which it occurs: in what context, for what purpose and if possible, who wrote it, and for whom it was written. On this basis, the analysis of this speech can be used for sociological analysis alongside an interview provided you avoid making it tell more than it can say. However, 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.

3 The path-dependency approach as an analytical framework

The path-dependency approach allows us to build on elements of the past to understand the structuring of the medical profession within the health system and to demonstrate how historically the unexpected long-term effects of the hospital reforms of 1958 created budgetary pressures that constrained the professional integration of non-EU/EEA doctors within the French health system.

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 2000; Pierson 2000; Steinmo 2001). It has borrowed from the work of the economic historian Paul David (1985) and 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 follow the most efficient way. The most classic example of 'lock-in' technology is that of the typewriter keyboard (David 1985)[4]. The assumption here is that when a track is followed, it becomes irreversible, even if it leads to sub-optimal outcomes (Thelen 1999:385). In the new institutionalism perspective this means that institutions[5] 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 quoted by Steinmo 2001). According to Mahoney (2000) there are three common and converging points of analyses using the path-dependency: they all involve a study of causal processes highly sensitive to events that occurred in the past within a global historical order. 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.

To return to medical migration, the path-dependency approach presents some limits which prevent it 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 will also consider the policy change perspective (Kingdon 1984; Steinmo et al. 1992; Joppke 2007; Schmidt and Radaelli 2005; Streeck and

[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).

[5]The definition of institutions as envisaged in the institutionalism perspective is that the institutions are not the passive recipient of social demands (classes, groups, preferences), neither the result of their actions, but they also have a fundamental effect in the political and social events by influencing actors, and the way in which they define their interests and identities (Mahoney 2000; North 1990; Pierson 2000; Steinmo 2001). In other words, institutions are not neutral arenas; they distribute power unequally between groups and social workers, promoting or limiting collective capacity of action (Merrien 2002).

Thelen 2005) which allows us to interpret the impact of reforms in the medical professional field and how they maintain non-EU/EEA doctors in an inferior professional position.

4 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). According to the text:

> Nobody shall practice as a doctor if he has not ... the French nationality, or an Andorran citizenship or from a European Union country or party to the Agreement on the European Economic, from Morocco or Tunisia, subject to the application, if any, of the rules set out in this chapter, or those resulting from international commitments other than those mentioned in this chapter ... (Cnom 2012c).

Concerning the diploma under condition two, doctors with French degrees have all successfully passed the *numerus clausus* examination, which occurs at the end of their first year of study. In the sixth year of academic study they also have to pass the National Classifying Examination *Epreuves Nationales Classantes*. Students are ranked according to academic achievement with those scoring higher being granted greater vocational choice[6]. Since the creation and strengthening of the EU and the Agreement on the European Economic Area, European citizens who have graduated from a European university have been granted the same rights as French graduates as stipulated in Law N° 76-1288, 31 December 1976 (Cnom 2012c)[7]. However, it states that, 'doctors who do not meet one or the other conditions, or the first two conditions laid down in Article L.4111 Code of Public Health, can be authorised to practice in the medical profession through dispensation or an individual order from the Minister of Health' (Cnom 2012b). Some of the non-EU/EEA doctors benefited from these measures in the 1970s and 1980s and have obtained the right to fully practice due to two reasons. The first was due to the creation of the individual license to practice and secondly because the diplomas of their countries were automatically recognised before the 1970s – the medical careers in France has been reformed after this period. For example the Maghreb countries, and some sub-Saharan Africa countries under French colonisation and during the years following independence.

Considering the statutes 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 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 statues – attached practitioners associates, associates assistants, acting as interns (*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'[8] refers to the non-EU/EEA doctors who are unable to become

[6] The second cycle of medical studies (at the end of the sixth year) in France ends for all students by national ranking examinations (NRE). They have replaced, since 2004, the examination of internship. Following its ranking, the student chooses their hospital university centre for posting and as well as their speciality.

[7] This agreement between the EU and Iceland, Liechtenstein and Norway includes provisions for the effective exercise of the right to settle and recognition of professional qualifications required for the exercise of the medical profession" (Cnom 2012c).

[8] 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 specialities non-validated by consultation commissions, and practitioners who are graduate doctors but registered as students.

integrated into the hospital medical profession via authorisation procedures but nevertheless continue to practice medicine through subterfuges used knowingly by hospital administrations (Couffinhal and Mousquès 2001a; Le Breton- Lerouvillois 2007). This last group practice medicine, recognised by all the stakeholders of the system, although they officially have no right to practice. This led Ferret (2012) to say that 'French medicine has its undocumented'.

Officially, there is no consensus surrounding the number of the non-EU/EEA doctors (Cash and 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 were doctors with French diplomas[9] who meet all the tests of 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 nationality during their stay, or French citizens who have been trained outside of the EU/EEA countries. The data from the College of Physicians 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 – the Federation of Health Practitioners – estimated non-EU/EEA doctors to number 17,000 in France (Cottereau 2012a:1). This conflicting data drove Le Breton-Lerouvillois, author of various publications for the French College of Physicians, to state:

> We have chosen to work on the nationality of doctors and not on the origin of the degree. Therefore, we do neither treat doctors of foreign origin who acquired French nationality during their stay on our territory nor the French doctors who obtained their medical degrees abroad. Moreover, we do not have the necessary visibility to address the difficult issue of non-European doctors, not registered in the College of Physicians, but who are practicing in our hospitals (2007:3).

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 diploma primarily practice in the private sector, where they have the ability to supplement their state salary by charging private rates (Cnom 2013:117).

5 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

[9]In 2006, this percentage represented 96 percent of doctors of French nationality and who graduated in France (Cash and Ulmann 2008:67).

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.

5.1 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; Hassenteufeul 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 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, along with the exhibition of a hostility to 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 common characteristics of closed markets are to protect the workers they employ against competition on the open labour market and, more broadly, against competition between colleagues. According to Paradeise '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' (1984:357).

5.2 The imprint of the past

The situation regarding the recruitment of non-EU/EEA doctors in France results from the structure of the medical profession, the role of the government in the health sector, the selective employment route into the field (Freidson 1985; Hassenteufel 1997; Herzlich et al. 1993), and also the budgetary pressures (Immergut 1992). First and foremost, from the early twentieth century French doctors have succeeded to stymie attempts to incorporate the profession in a binding national health insurance system (Ferro 1985; Leonard 1981). In 1927 they adopted the *Charter of the Liberal Medicine*[10] which involved the creation of a professional corporation with extensive powers (Hassenteufeul 1997:18). According to Hassenteufeul neither the *Social Insurance Laws* of 1928 and 1930, nor the implementation of social security after 1945 succeeded in questioning their professional prerogatives and power over the practice of the profession. Hassenteufeul 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 French doctor has a very high conception, of his duties, of all his duties. But we see alas other doctors, product of easy 'equivalence', and coming from afar, sell their medicine in our country, as carpets are sold in outdoor cafés, providing a mentality that we would see reserved for their countries of origin (1997:38).

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

[10] 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.

by the extreme right. Xenophobia in the sense of Deplaude (2011)[11] 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 profession (Hassenteufeul1997). As Henri Nahum wrote:

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

It was in this context that the slogan 'France for the French' received wide coverage and manifested itself in French doctors mobilising themselves in favour of a bill by Dr. Ambuster, passed in 1933, strictly reserving the practice of medicine in France to French citizens who held a French degree. In addition, the bill expressed a fierce reservation regarding the naturalisation of foreign doctors. However, the new French Constitution and the advent of the new Republic from 1945 at the end of the World War II did not change the principles of the French College of Physicians, especially with regard to the main objectives set during the previous years, whose effects can still be witnessed in the present day.

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 remains in force to this day 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 with the introduction of the Individual License to Practice Act 1972 which introduced the granting of individual license to practice to foreign doctors (Couffinhal and Mousquès 2001a). Even today representatives of the College of Physicians in France are echoing some of the historical ideals outlined above.

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

The exclusion of foreign doctors was further strengthened with the introduction of the *numerus clausus* examination in 1971, which was introduced by Simone Veil. In general, the term of *numerus clausus* refers to 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 and 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[12]. 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

[11] Inspired by Miles and 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'.

[12] A new reform of 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).

entry into the second year. The number of positions offered is very low compared to the number of students registered in medical school[13]. Unlike the other established admissions procedures implemented in other European countries, this procedure ignores student motivation and previous social experience; instead it takes the form of multiple selected questions (MCQs) on scientific issues (Hardy-Durbernet and Faure 2006:15). The preparation for *numerus clausus* competition for the young students necessitates a considerable workload. As Verdoot points out, the *numerus clausus* is primarily 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 requires 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 and Faure 2006; Deplaude 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 competent doctors versus less competent doctors (Dubar 1998:18) is imposed with a crystallisation of historically stubborn prejudices, either they are objective or subjective, implicit or explicit. Such prejudices are rooted in the views of public opinion and often are 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 and Ulmann 2008).

6 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 as 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 internship in hospitals – the only means of access to surgical specialities – or by the Certificate of Specialized Studies (CES) (Hardy-Dubernet and Faure 2006:11).

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

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

Internships for a speciality were established by the Law of 31 December 1982. With the internship speciality, intern positions depended on national legislation while positions for the CES were left to the discretion of the Faculty (Cnom 2012). Doctors in CES positions received no pay and had no official position in the hospital where they practice their internship. Regulating access to specialities allowed the government to limit the number of positions in any given speciality. However, the 1982 reform failed in its ambition to upgrade general medicine as it still could not attract the best medical students (Hardy-Dubernet and 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 and Faure 2006)[14].

A 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 change of political ideology in France, which was influenced by international political thought regarding the reduction of state-based welfare. France undertook a review of its fiscal policy and as Streeck (1992) highlights, the change in policy agenda was influenced by the declining value of the franc in the early 1980s, which led France to abandon its experiment in strong Keynesian economic management and to introduce welfare cuts and a programme of de-nationalisation. Control of health expenditure became an important issue after the failure of several attempts to restructure the sector (Cash and Ulmann 2008:61), and it was in this context of profound change which were considered by some to be 'brutal and complete' (Merrien et al. 2005:345–347).

According to the expectations of the time, 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 and Ulmann 2008:61)[15]. The 1958 hospital reform thus sets a hierarchy and a rigid separation between the noblest hospital functions and private practice, which is less noble 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 recruitment of many graduates from outside the EU/EEA. Moreover, Xavier Deau, President of Medical Training and Skills in the French College of Physicians emphasised that '*numerus clausus* imposed on French students... is one of the etiologies of the massive influx of foreign students since the 1990s' (Deau 2006:2).

7 Difficulties in responding to needs

Rather than the intended reduction in hospital expenditure, these reforms of public hospitals have led to increased medicalisation of hospitals, which has resulted in a higher requirement for medical

[14] '…their only goal is to classify the students are assessed on their knowledge by universities. The events take place throughout the territory, the same day for all students of all French faculties of medicine; they therefore have no direct link with the universities. All students will then select a speciality for practice, including general medicine. This procedure was designed to give again a real mission to universities; to ensure the acquisition of basic skills among students, who then will be allowed to sit the ECN examination from a strictly academic program' (Hardy-Dubernet and Faure 2006 :7).

[15] '...medical health unions, health insurance as well as the government agreed to reduce the number of trained physicians. Conversely, the Deans of Faculties of medicine have always seen this policy as a problem, particularly for running hospitals - a portion of hospital activity is carried out by interns and *Faisant fonction d'internes*'. The College of Physicians, drawing on his work on demographic projections, also oppose quite quickly to this too drastic reduction in the number of students.'

personnel doctors. (Cash and Ulmann 2008; Couffinhal and Mousquès 2001a). However, these positions can no longer be filled through the usual channel of medical students who have passed the internship. In this context, the combination of the declining number of doctors and increased needs led hospitals to employ, in considerable proportions, doctors with foreign degrees[16]. It was easy to implement this policy because many doctors from the Maghreb and the Middle East had settled in France both for 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 et al. 2005:347).

7.1 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. 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 significant budgetary costs in a context of ideological and economic change. Second, it would mean the government would have to contend with opposition from the French doctors' unions who are strongly opposed to the recognition of non UE/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 in terms of implementation of the 1991 Act. In 1995, the Steg Report on emergencies once again raised the question. The Steg Report showed that in many public hospitals the reception of patients, in certain specialities, was entirely overseen by interns and the non-EU/EEA doctors under the status called interns ('*Faisant Fonction d'Internes*'). The report stressed a large number of vacancies in some sectors, particularly in that of anaesthesia.

The year 1995 marked the culmination of the reformists' will. On February 4 1995, the Weil Act, implemented in a context of fiscal crisis and xenophobic tensions[17], presented as law 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 new status called CAP. Unlike other hospital doctors, CAPs are not permanent, but contractual, however faced with 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 expanded by increasing the annual quota. Permission to practice general medicine was given

[16] In 1994, the number of doctors with non-EU/EEA degrees was estimated at 8,000 in French public hospitals (Couffinhal and Mousquès 2001a).

[17] We recall that 1995 began under the sign of political cohabitation (President François Mitterand, Prime Minister Edouard Balladur), and extended through the elimination of Lionel Jospin in the presidential elections and the confrontation between Jean-Marie Le Pen of the National Front and Jacques Chirac of the Rally for the Republic Party ('*Rassemblement pour la République')* in the second round of the presidential election, which ended with the election of Jacques Chirac.

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 any recruitment of new graduates from outside the EU after 1999. Finally, it appears that the vision of French authorities to rationalise non EU/ EEA doctors has been defeated by the 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 as having 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.

7.2 The interests of actors in the heart of the controversy

The analysis of the interviews we 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 failure to obtain a French diploma, working conditions and 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 in 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, interviewed in 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 in postponing deadlines until a more favourable and less sensitive time to the union's demands[18]. 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

[18] Deplaude (2009) shows how the establishment and implementation of the *numerus clausus* of medicine in the 1970s in France can see what constitutes 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 institution of the *numerus clausus*, contributing between the mid-1970s and the late 1980s, and an unprecedented population growth of the medical profession in France.

> then implementing them progressively according to changing circumstances and political power relations (2009:20).

As for 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 and 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, and mirrored by official declarations from the French College of Physicians. Firstly, the vast majority of doctors with French degrees consider it a legitimate norm that a duality operates within the French healthcare system. For some, the 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.

> Understand the astonishment and anger of the French when, after having announced to them years ago that the *numerus clausus* should be reduced or cancel specialities, because there were too many doctors, we explain to them that they have to let foreign doctors come (medical student, discussion forum, discussion forum 'Foreign doctors, second-rate practitioners in France', 19 June 2008).

> I do not see why the citizens of a country should accept when they have duties, they pay taxes, they elect their leaders that are placed in a situation of permanent competition with non-national workers (medical student, discussion forum 'Foreign doctors, second-rate practitioners in France', 19 June 2008).

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 called into question. 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 of benefit both to their countries and to 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).

However, the College of Physicians did not deny the need to fill the current deficit of 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).
>
> But the arrival in May 2004, of ten new Member States has created a difficult situation to manage. Europe could no longer apply the rules on the harmonisation of competences, with health professionals who do not always provide the guarantees of required skills given their heterogeneous paths (Arlette Chabrol, BOM, No. 3, March 2006).

This paper will now move to present the opinions of the African doctors with non-EU/EEA degrees that were interviewed in Paris, however it is important to note these views were also reflected in the analysis of union's publications, internet forum discussions and academic literature. The African doctors with non-EU/EEA degrees that we met in Paris, when they described their professional trajectories, 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 conducted in the Paris region revealed that there is constant disillusionment among the African doctors with non-EU/EEA degrees faced with a career, that we have defined as part of our typology model,[19] of a 'blocked' professional career. To clarify this we mean '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 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, we now turn to discuss the limitations of the path-dependency approach in explaining the non-EU/EEA issue.

8 The limits of path-dependency approach in the explanation of transformations related to reforms

In short, the path-dependency approach can help 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. As has been shown, the medical profession as closed labour market responds to the characteristics of the corporatist organisation that practices the regulation, the legal discrimination and crucially defends the

[19] We distinguish three types of professional careers of physicians with African diplomas. The model of 'successful career' means a model in which the graduate in African medicine may undertake a professional career in Europe identical to those of European nationals. There is not a barrier to entry, neither a duality between national citizens nor the non-nationals in the exercise of the profession. Although the phenomena of racism and stigmatisation throughout the career cannot be excluded, the law makes no distinction based on the origin of the diploma. This situation is the one that typically characterised the UK until the mid-2000s. The 'impossible career' model refers to the situation of African doctors in Switzerland. The system is very closed; it responds to a limited and selective binding preferential logic based on three circles (Swiss, European and Others) and makes it almost impossible to get job in the medical field unless naturalised Swiss or European (Mendy 2014:51).

interests of its own members. It is also characterised by an important power of negotiation and the historical capacity to exclude those the profession does not want as members.

The path-dependency approach also claims that national policy trajectories are locked into inert patterns (Steinmo, Thelen, and Longstreth 1992; Pierson 2000). In this logic, this assertion needs to be qualified in some respects with regards to the issue of the professional integration of foreign doctors working in France. In fact, the situation of foreign doctors is not subject to an inherent determinism since labour negotiations and the various reforms implemented since the 1980s and 1990s by French governments created the change by allowing the regularisation of a large number of doctors with non-EU/EEA degrees. In fact, many contemporary studies cited below have focused on the failure of theories of path-dependence to account for social change. In many areas, there seems to be much less inertia (Mahoney 2000) than has previously been assumed by the theory. National policies even when considered relatively stable and included in national heritages such as economic and social policies (Scharpf and Schmidt 2000) or migration policies in Europe (Joppke 2007) have suffered severe transformations that erase their original features and lead them to a form of convergence. These transformations have been traditionally explained by theorists belonging to the school of historical neo-institutionalism as the result of 'critical junctures' of 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 changing the frame of reference and the dominant discursive structure (Jobert 1987; Schmidt and Radaelli 2005). 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*, Wolfang Streeck and Kathleen 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, my research shows two significant results.

Firstly, it is undeniable that the French medical system has undergone a series of transformations unthinkable in the strict sense of path-dependence approach. These transformations fit perfectly with the logic of 'institutional layering' analysed by Thelen and Streek (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 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 finance 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.

Secondly, there is no change of 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 which are recognised in other countries (e.g. the UK). In France, it remains the case that that they may engage only in subordinate roles. Significantly, the recruitment policies of non-EU/EEA doctors continue to highlight the imprint of the past and reveal a significant persistence of prejudices that some authors such as Mbembe (2005) stressed when they talked about the colonial practices. In fact 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 so than in French society as a whole. In this sense, the institutional systems are more than just legal system and, as pointed out by James, March and Olsen (1989), institutions are a relatively enduring collection of rules and organised practices, embedded in structures of meaning. The rules may change incrementally, but the structures are provided which create inertia. For example, in the context of the practice of medicine, discussion forums of French doctors we have analysed demonstrate the existence of a deep-rooted 'colonial' attitude to African doctors and their degree qualifications as insufficient. Otherwise, by explicitly excluding the norms and values built by the institutions to retain only formal institutions, which create obligations, authors such as Streeck and Thelen (2005) deprive themselves of the opportunity to analyse the persistence of behaviour, taboos that stand in sometimes paradoxical pressure of new needs. 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.

9 Conclusion

The French authorities mainly use ethical reasons to justify their refusal to recognise non-EU/EEA doctors in France. As they often say, the non-EU/EEA doctors, mostly those coming from Africa, have to return to their country to treat their populations. This paper goes beyond the political controversy and shows that the situation of non-EU/EEA doctors in France derives objectively 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, the unexpected long-term effects of hospital reforms of 1958 and budgetary pressures. Based on the path-dependency approach this paper demonstrates two significant findings. Firstly, the French medical system has undergone a series of transformations unthinkable in the strict sense of the path-dependence 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. Secondly, there is no change of the overall paradigm. Significantly, the recruitment policies of non-EU/EEA doctors continue to highlight the imprint of the past and reveal a significant persistence of prejudices. Non-EU/EEA doctors are not considered legitimate doctors even if they have the qualifications of physicians which are legitimate in their country and which can be recognised in other countries. They may engage only in subordinate roles. At the same time, the opening-up of the EU tends to restrict the residual place and further marginalise the non-EU/EEA doctors. Indeed, as far as recruitment is concerned, France is increasingly finding alternatives to physicians from new member countries of the EU as mentioned by the officials of the French College of Physicians. The latter can continue to draw on the dominant ethical discourse which denounces the medical migration from developing countries even though the speech 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 profession (Mendy 2010; Peterson et al. 2013). Imbued with these arguments, unions of doctors with non-EU/EEA degrees in France are seeing their margin of negotiation being reduced. In addition, recent reports on medical demography in France (Cnom 2013) 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 this trend may further contribute to the marginalisation of non-EU/EEA doctors.

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