Middle Articles

British Physicians on Medical School Faculties in North America

T. C. GIBSON,* M.B., M.R.C.P.

Brit. med. J., 1967, 1, 688–692

Data on the movement abroad of British medical graduates have been published by several investigators, notably Seale (1964, 1966), Davison (1962), Last (1963), Whitfield (1963), and Abel-Smith and Gales (1964). Different methods have been used to collect such information, and this has led to problems of validity, though, in spite of past Governmental statements, it appears that medical emigration has been considerable. One well-designed study estimates that nearly 500 physicians went abroad each year from 1955 to 1960 (Abel-Smith and Gales, 1964), and Seale (1966) indicated that a numerically similar exodus has continued up to 1965. This represents an important loss of educational investment for the United Kingdom, and terms such as "brain drain" have been used, usually based on isolated and publicized examples. Little attempt, other than that of Abel-Smith and Gales, has been made to evaluate the motives and achievements of physicians who have emigrated, though these matters should be of some interest to those who are responsible for medical administration and education in the United Kingdom. Such facets of medical emigration led to this study of physicians with British medical degrees who are on the faculties of North American medical schools. The whole topic of medical emigration can stir up such emotion that a rational evaluation may not be forthcoming. Nevertheless, it was felt that, apart from documenting numbers, an attempt should be made to obtain a perspective of the personal reasons for making such a major professional move.

Materials and Methods

The initial step was to list all those physicians with registrable British medical degrees who were on the faculties of American and Canadian medical schools on 1 July 1965. Only institutional members of the Association of American Medical Colleges were included, a total of 87 schools in the United States and 12 in Canada. Copies were obtained of all medical school catalogues for the academic year 1965–6, since these normally include a register listing the academic status of faculty physicians and their qualifying medical degrees. Next a letter was written to the deans of these medical schools asking for the names of all British-trained medical graduates on the school faculty. Confirmatory information concerning qualification was obtained by checking all names by means of the *Medical Directory*, the *Medical Register*, the *American Medical Association Directory*, and the *Canadian Medical Directory*. The criteria to be used for inclusion in the study were: (1) the physician was of British nationality before emigrating; (2) he had a British registrable degree; (3) he was on the permanent active staff of a North American medical school, in either a part-time or full-time capacity; (4) he was not about to leave for a post outside North America; and (5) he was not a transient, abroad in North America specifically for postgraduate training.

Additional data were collected by questionary in the latter half of 1965. The physician was asked to give information on his academic status and work, previous appointments in the United Kingdom, age, year of emigration, nationality, influencing factors leading to emigration, ease of obtaining a licence to practise, intention of remaining in North America, and general comments. Attached to the questionary was a list of those British-trained physicians who were believed to be on the staff of that particular medical school. The list was to be checked by the respondents, adding or subtracting names as was appropriate, and the information returned as soon as possible in the reply-paid envelope provided. Non-respondents were approached a second time, and, if they again failed to return the questionary, a third time. Those who did not reply at all were the subject of letters of inquiry into the medical school in order to make certain that they fell within the criteria used for selection.

Study Population

One or more questionaries were sent to 865 individuals. A total of 669 physicians—342 in the United States and 327 in Canada—qualified for inclusion in the study. A total of 631 answered the questionary, this being a 94% return. There were 196 physicians who did not qualify and were excluded for various reasons. British qualifying degrees had been obtained by North American native-born citizens in 81 instances, though only 13 had qualified after 1944. It is of interest that 49 of these physicians attended Scottish universities. The majority of physicians who had returned or were returning to the United Kingdom were going to consultant posts. The remainder could not be included because they were not of British nationality before emigration, were not on the permanent staff of a medical

TABLE I.—*Physician Data*

	U.S.A.	Canada	Total
Included in study population:			
Respondents	322	309	631
Non-respondents	20	18	38
Total	342	327	669
Not included in study population:			
American or Canadian by birth	53	28	81
Other non-British citizens	21	9	30
Returned to Great Britain	19	5	24
Returned elsewhere	2	2	4
Died	1	4	5
Non-qualified	34	18	52
Total	130	66	196

* Associate Professor, Department of Medicine, University of Vermont College of Medicine, Burlington, Vermont, U.S.A.

school, or had died. The study population figures are summarized in Table I.

Results

There were physicians in the study population on the faculties of 70 out of 87 United States medical schools and of 10 out of 12 Canadian medical schools. The 342 physicians in the United States were mostly full-time faculty, and this group represented 66.7% (228) of the total. The position was reversed in Canada, where of 327 faculty members 36.4% (119) were full-time. There was accordingly a similarity between the total number of full-time (347) and part-time (322) physicians in North America. In evaluating the results of the study it is essential to understand the wide variability of academic commitment for a part-time physician on the faculty of a North American medical school. He is usually a physician whose income is from private practice and he may participate either minimally or to a considerable degree in academic affairs. He may be on the faculty of a medical school for geographically fortuitous reasons, since such an appointment may be a useful perquisite. This contrasts with the full-time academic physician who is normally salaried and not dependent on practice for his livelihood.

Year of Emigration

The majority of physicians emigrated in the decade 1950 to 1959, and the year of maximal emigration was 1957. This was similar for both those who went to the United States and those who went to Canada. Only 2.1% emigrated before 1945, and 17.9% left the United Kingdom after 1960 (Table II). From 1957 onwards there was a marked fall in the number of emigrating physicians who would qualify for this study. Nevertheless, during the period 1960–4 those who did emigrate were three times as likely to be in full-time academic posts when compared with those who were part-time. From 1945 to 1959 there had been little difference numerically between the two groups.

TABLE II.—*Year of Emigration*

	U.S.A.		Canada		Total		Overall Total	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	No.	%
Before 1945	5	4	4	1	9	5	14	(2·1)
1945–9	18	14	13	26	31	40	71	(10·6)
1950–4	48	32	29	70	77	102	179	(26·8)
1955–9	80	45	43	79	123	124	247	(36·8)
1960–4	62	11	24	16	86	27	113	(16.9)
After 1964	3	0	3	1	6	1	7	(1·0)
Unknown	12	8	3	15	15	23	38	(5·7)

A total of 82 physicians did not make a direct move to the United States or Canada, but emigrated to one country from the United Kingdom and re-emigrated to the other. The movement was in favour of the United States, which gained 28 full-time and six part-time physicians from Canada. In addition, 24 physicians came to North America from another country, to which they had originally emigrated from the United Kingdom.

TABLE III.—*Length of Time Qualified on Emigration*

	U.S.A.		Canada		Total		Overall Total	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	No.	%
On qualification	5	2	1	6	6	8	14	(2·1)
1–5 years	71	39	38	56	109	95	204	(30·5)
6–10 years	69	37	34	69	103	106	209	(31·2)
11–15 years	53	21	29	51	82	72	154	(23·0)
16–20 years	8	6	7	9	15	15	30	(4·5)
More than 20 years	10	1	7	2	17	3	20	(3·0)
Unknown	12	8	3	15	15	23	38	(5·7)

It was clear that the decision to emigrate was made relatively early in the medical life of a physician, and two-thirds had taken this step within 10 years of qualifying (Table III). If a physician had been qualified for more than 15 years he was most unlikely to emigrate. There was little difference in trends between those who had full-time academic posts and those who were part-time.

Medical School

Nearly a third (31.7%) of emigrating physicians were trained in the London medical schools (Table IV). This does not include Oxford and Cambridge graduates who took their clinical work in London. The second largest group came from Scotland (28.8%). Oxbridge graduates (17.2%) accounted for as many emigrants as the combined provincial English and Welsh medical schools. There was no striking difference in medical school origin between full-time and part-time physicians, with the exception of Oxbridge graduates, who were more likely to be in full-time academic medicine. Data obtained, but not included in this study, indicated that an additional 97 physicians who had qualified from medical schools in the Republic of Ireland were on the staff of North American medical schools. If a total figure including these physicians is considered then they accounted for 12.6% of those who had emigrated.

TABLE IV.—*Medical School*

	U.S.A.		Canada		Total		Overall Total	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	No.	%
London	68	42	37	65	105	107	212	(31·7)
Scotland	50	31	36	76	86	107	193	(28·8)
Oxbridge	54	16	21	24	75	40	115	(17·2)
Provinces	41	18	18	27	59	45	104	(15·5)
Northern Ireland	9	5	7	15	16	20	36	(5·4)
Wales	6	2	0	1	6	3	9	(1·3)

Previous Rank

The rank held in the United Kingdom immediately before emigration was most likely to be house-officer (16.4%), registrar (18.5%), or senior registrar (13.3%). A surprising number of consultants had emigrated, 61 in all (9.1%), and lecturer grades (8.5%) were also well represented. There were 38 general practitioners, and 17 of these had achieved full-time academic status in North American medical schools. Some of them were physicians who had been "forced" into general practice by the then current state of difficulty in obtaining consultant appointments. The results are summarized in Table V.

TABLE V.—*Previous Rank*

	U.S.A.		Canada		Total		Overall Total	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	No.	%
Consultant	19	9	11	22	30	31	61	(9·1)
Senior registrar	25	11	20	33	45	44	89	(13·3)
Registrar	42	29	18	35	60	64	124	(18·5)
House officer	37	21	17	35	54	56	110	(16·4)
S.H.M.O., J.H.M.O.	4	1	0	8	4	9	13	(1·9)
S.L., L., J.L.	27	4	23	3	50	7	57	(8·5)
Practitioner	11	11	6	10	17	21	38	(5·7)
Other	34	11	13	19	47	30	77	(11·5)
None	5	3	1	6	6	9	15	(2·2)
Unknown	15	10	6	27	21	37	58	(8·7)
Services	9	5	4	9	11	16	27	(4·0)

Specialty

The largest number of emigrants (21.5%) were presently employed in internal medicine and its subspecialties (Table VI). The majority of these were in the United States and in full-time academic positions. Surgery was the next best represented

(13.0%), and the largest subgroup in this specialty was the part-time surgeon in Canada. There were almost as many psychiatrists (12.6%) as surgeons, and this must be a disproportionately high number. Pathology, anaesthetics, and paediatrics were well represented. There were a small number of medically qualified individuals in the basic sciences (7.2%), and, as might be expected, they were predominantly full-time. A smaller number of radiologists, obstetricians and gynaecologists, and specialists in preventive medicine were included. There were no physicians who described themselves as general practitioners. The two other specialties represented include one professor of medical statistics and one professor of medical history.

TABLE VI.—*Specialty*

	U.S.A.		Canada		Total		Overall Total	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	No.	%
Internal medicine	62	37	18	27	80	64	144	(21·5)
Surgery	16	20	11	40	27	60	87	(13·0)
Psychiatry	27	16	11	30	38	46	84	(12·6)
Pathology, Bacteriology	27	13	15	20	42	33	75	(11·2)
Anaesthetics	22	14	9	27	31	41	72	(10·8)
Paediatrics	21	4	16	21	37	25	62	(9·3)
Basic sciences	21	1	23	3	44	4	48	(7·2)
Radiology	11	2	7	23	18	25	43	(6·4)
Preventive Medicine	12	3	5	8	17	11	28	(4·2)
Obstetrics and Gynaecology	8	4	4	8	12	12	24	(3·6)
General practice	0	0	0	0	0	0	0	(0·0)
Other	2	0	0	0	2	0	2	(0·3)

Academic Status and Work

There were 109 full professors, of whom 42 were department heads. Full-time faculty were mostly in the associate professor grade, and part-time faculty in the "other ranks" grade (Table VII). The large number of other ranks held by part-time physicians in Canada reflected the nomenclature used for the relatively large part-time faculties, since they may be called clinical teachers, associates, or demonstrators. All respondents were asked to indicate the percentage of time taken by research, teaching, patient-care, administration, and other duties. It was found that 88.8% of full-time faculty do research, as contrasted with 46.9% of part-time faculty. This indicates that part-time faculty were able to combine practice with research in a relatively high proportion of instances. Teaching duties were listed by 91.1% of full-time faculty and by 88.5% of part-time faculty. Patient-care was less commonly a function of full-time faculty (61.2%) as compared with part-time faculty (86.0%). A sign of the times was that 55.6% of full-time faculty were concerned with administration, and even 38.5% of part-time faculty were involved in this area.

TABLE VII.—*Present Rank*

	U.S.A.		Canada		Total		Overall Total	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time	No.	%
Professor, head of department	20	1	19	2	39	3	42	(6·3)
Professor	47	4	13	3	60	7	67	(10·0)
Associate professor	63	9	43	10	106	19	125	(18·7)
Assistant professor	65	38	27	41	92	79	171	(25·6)
Instructor	29	54	6	45	35	99	134	(20·0)
Other	4	8	11	107	15	115	130	(19·4)

Influencing Factors

All respondents were asked to indicate three factors that influenced their decision to emigrate. Eight possibilities were listed, and these included improved research facilities in North America, advantages for family (climatic, educational) in North America, dissatisfaction with conditions of work in the United Kingdom, improved academic position in North America, research opportunity with a special person or team in North America, better economic conditions in North America, dissatisfaction with promotion opportunities in the United Kingdom, and better postgraduate training facilities in North America. Any other factors which were not listed were also solicited.

Data derived from such a list are subject to some criticism. The choices might be biased, and it could be very difficult for individuals to evaluate correctly the weighting of their answers when limited to three possibilities. The most frequently listed influencing factor was dissatisfaction with promotional opportunities in the United Kingdom (Table VIII). This was indicated by 49.4% of the respondents. Better economic conditions in North America clearly influenced part-time faculty, who listed this first. This was less important to the full-time faculty, but when the groups were combined it was mentioned by 44.7% of the respondents. Dissatisfaction with conditions of work in the United Kingdom was also important (38.8%), and was listed as third overall by part-time faculty and fifth by full-time faculty. Improved academic position in North America was listed by 30.0% of all physicians answering. It was a more important influencing factor for full-time faculty, and was listed second by them. Advantages for the family (28.7%) came close to improved academic position, but this influenced part-time faculty more. Improved research facilities were of considerable importance for full-time faculty who emigrated to the United States and relatively unimportant for all part-time faculty. Better postgraduate facilities were not considered important by either part-time or full-time faculty. Research opportunity with a specific person or team was not expected to be high on the list of influencing factors, but did play a part in the decision of 52 full-time faculty members. Other factors listed by the respondents were related to personal matters such as marriage, relatives, politics, curiosity, wanderlust, and interest in a new environment or the specific offer of a post. One physician emigrated to spite his family and another to indulge in his hobby of bird-watching in a less crowded country.

TABLE VIII.—*Influencing Factors*

	U.S.A.		Canada		Total		Overall Total 631	
	Full-time	Part-time	Full-time	Part-time	Full-time	Part-time		
	216	106	116	193	332	299	No.	%*
Dissatisfaction with promotion opportunities	99	56	55	101	155	157	312	(49·4)
Better economic conditions	63	55	51	113	114	168	282	(44·7)
Dissatisfaction with conditions of work in U.K.	61	53	35	96	96	149	245	(38·8)
Improved academic position	83	21	52	33	135	54	189	(30·0)
Advantages for family	45	29	32	75	77	104	181	(28·7)
Improved research facilities	97	9	33	11	130	20	150	(23·8)
Better postgraduate facilities	41	25	6	22	47	47	94	(14·9)
Research opportunity	37	6	15	7	52	13	65	(10·3)
Other	53	33	24	50	77	83	160	(25·4)

* Since a respondent could indicate up to three factors the percentages are not additive to 100%.

The physicians were also asked if they were influenced in their decision to leave the United Kingdom by university attitudes to research. As might be expected, only a small proportion (15.5%) stated that they were so influenced. It came as no surprise that there were far more full-time faculty who were influenced in this way—27.0%, as opposed to 8.0% of part-time faculty. The questionary asked specifically whether a decision to leave the United Kingdom was influenced by conditions in the National Health Service. Those who replied were nearly evenly divided in their answers, since 313 did not regard this as an influencing factor and 308 did. Further examination of the figures indicates that there is a striking difference between

the full-time and the part-time physicians in this respect. Negative replies were obtained from 62.1% of the full-time physicians, but 62.6% of the part-time physicians stated that they were so influenced.

The great majority of physicians (77.3%) intended to remain in North America. Only 3.3% said categorically that they had no intention of staying, and 13.8% were uncertain. A further method of evaluation of intent to remain might be to find the number who had become naturalized in their country of adoption. A total of 44.2% had become citizens of the United States or Canada. There were proportionately more United States citizens than Canadian citizens, and it is possible that this was due to the fact that many States in America first required naturalization before they would consider the issue of a medical licence to practise. In this context, when asked if they had had difficulty in obtaining a licence to practise, there was a striking discrepancy between answers from the United States and Canada. A total of 21.6% of those in the United States had had difficulty in obtaining a licence as opposed to 5.5% in Canada. The difficulty was usually related to compliance with regulations of individual States and often administratively frustrating rather than academically challenging.

Discussion

The methods used in obtaining the sample make it very likely that the total must be close to the actual figure in 1965 of British physicians who were faculty members of medical schools in North America. Information concerning medical degrees and academic status was obtained from official sources and checked by official records. Only one individual could not be traced in this manner, and he was contacted direct in order to confirm data. The subjective information obtained by questionary is more difficult to evaluate, since this method has inherent difficulties which are well known. Answers which might relate to personal judgements are prone to bias owing to individual influencing factors. Nevertheless, it can be implied that information derived from a 94% response could be reasonably accurate when applied to the whole group.

The data for our study population show that there was a steady rise in emigration from 1945 to 1957, a sharp decline to 1961, and a slight rise in 1963. Superficially it seems that there is now less emigration to North America of this particular group of physicians, but this may be accounted for by delay in obtaining medical licensure and further time spent in training and obtaining an academic appointment. All these factors could give rise to a time lag prior to obtaining an academic appointment. Abel-Smith and Gales (1964) stated that 30% of the 500 British-born physicians emigrating to the United States during the years 1955 to 1960 were in academic posts. In the present study it was found that 144 full-time and part-time academic physicians emigrated to the United States during this time. This figure corresponds well with their estimate of 150, but if part-time physicians are excluded then they overestimated by nearly 100%.

A surprising number of physicians in our study population emigrated within one to five years of qualification ; they made up 30.5% of the overall total, and this was only slightly exceeded by those who emigrated within six to ten years of qualification. The loss of educational investment to the United Kingdom is even more striking on the basis of these figures, and this has been the topic of acrimonious debate in relation to the morality of such an action. The current status of those who have emigrated to North America indicated that many had achieved eminence in their specialty. Departmental heads numbered 42 and full professors 67. These appointments are not easily obtained, and indicate excellence in the appropriate area of the profession. It is a reasonable generalization that those physicians who have attained the rank of assistant professor and above may be thought to have achieved the equivalent of consultant status in the United Kingdom.

Reasons for Emigration

It is clear that the National Health Service is not held specifically responsible for emigration by the majority of physicians, especially those who are full-time, but there is evidence that certain associated dissatisfactions had an important effect on their decision to emigrate. Lack of promotion opportunities, dissatisfaction with conditions of work, and inferior economic conditions appear to be the most tangible influencing factors. The prospect of an improved academic position and opportunity to do research under improved conditions in North America was also important to full-time academic physicians. There was little consensus by this group that better postgraduate facilities existed in North America. All respondents were invited to comment and nearly half of them did. The comments reinforced from an individual point of view the predominating influencing factors as elicited by the questionary. They are selected by the very nature of their collection, but some express forcibly certain general feelings. The sheer rigidity of the promotion ladder in the National Health Service was mentioned on many occasions.

Some of the positive attractions of the North American system were well summarized by an associate professor in a department of medicine. He wrote: "I am able to function medically so that I enjoy my work, and the available facilities of this type of medical school make this remarkably easy. The combination of teaching and patient-care fulfils my goal, since I believe my capabilities lie in this area. I do modest research and I can expand or contract this at will. There is far more flexibility here. The perpetual challenges that go on in a good American medical school have made me a more critically minded and educated physician than I was when I emigrated. No one, least of all students, takes anything for granted, and I believe that this is a very healthy situation. Postgraduate programs are available and there is no problem concerning attendance, for this is an intrinsic part of medical life here. Although these programs are sometimes spotty, for the most part they are very useful if one is selective." There were many comments concerning indifference to research in the United Kingdom and frustration in obtaining funds for this purpose. Some thought they were prophets not without honour save in their own kingdom. Many who had been in the registrar and senior registrar groups had emigrated because of the obvious lack of consultant posts and they were not willing to wait. Others were more practical, such as the physician who wrote: "If you have something to sell, sell it in the best market—North America." Nepotism and the priority of teaching hospital trainees also came in for the expected criticisms. Some were aggravated that they were doing consultants' work without consultants' pay, frequently with little supervision.

Many other points were mentioned, such as the probability that the overproduction of physicians in Scotland must lead to emigration. This was well put by one physician, who observed that there was a tradition of several hundred years of "graduate and get out" in Scottish universities. It was also stated by some that the National Health Service had little to do with the present medical situation in the United Kingdom, since it was no more than the perpetuation of a structure of medicine established long before. The principle of the National Health Service was frequently lauded, though the administration came in for little praise. The whole structure of British medicine was felt by some to be biased towards the concept that policy-making was a prerogative of older men somewhat on the basis of "father knows best." Most seem satisfied with life in North America, but some were anxious concerning the education of their children, and others did not believe that the cultural advantages of North America were as great as those of

the United Kingdom. Several stated that they would return if there were equivalent posts available in the United Kingdom, but some who had attempted to return were apparently rebuffed. It is obvious that the majority intend to remain in North America on a permanent basis.

Loss to U.K.

By any standards the emigration of physicians that has been described is an important loss to the United Kingdom. In many instances academic achievement has been striking, and in other instances, usually in terms of part-time faculty, academic participation has been minimal. Nevertheless, the impression is that many physicians have been put in a position where they were able to develop and realize their potential, leading the satisfying medical life that they never achieved in the United Kingdom. It could be argued that this type of emigration has made little difference to the United Kingdom, since there is no lack of individuals to fill available consultant posts, especially in the major specialties of medicine and surgery. This may have been true, but it appears that a shortage of well-trained consultants already exists in other specialties. It could also be argued that many physicians emigrated in the past to various areas of the British Empire and that, since this avenue was now less open, they went elsewhere. The truth of such a statement has not been discounted.

Those physicians and administrators who guide the policies of the medical services in the United Kingdom have not been unduly concerned about physician emigration until recently. Some of those who had emigrated stated that they had been actively encouraged by senior physicians to do so, and little attempt was made in the past to stem any form of emigration that would lead to a relief of the registrar bottleneck. A basic solution would have been to establish more consultant posts several years ago in addition to the development of better academic facilities. It is very unlikely that the standards of medicine in the United Kingdom would have been anything but improved by such a move, and it certainly might have been more logical and preferable to invest in such a manner the annual sum expended on merit awards. The relatively small amount of money required to subsidize those physicians who might otherwise emigrate would have been very well spent. There is no present justification for complacency on the part of the Government in terms of retaining young men with considerable potential and high standards of excellence who are not satisfied with the *status quo ante*. There are those who would emigrate anyway, but, on the basis of the statements made by the group under study, lack of promotion opportunities was a major factor. It is probable that the other influencing factors which were mentioned most frequently were specific consequences of this. There is an element of tragedy in the wastage to the United Kingdom of all this medical talent, and it is hard not to place at least part of the blame on those responsible for the administration of the National Health Service.

Summary

A study was made in 1965 of physicians with British qualifying degrees who have emigrated to North America and who were on medical school faculties in a full-time or part-time capacity. Excluding those who were not British nationals, a total of 669 physicians were found to be in this category. A questionary was sent to all 669, and 631 (94%) replied.

There were approximately the same number of such physicians in Canada as in the United States, though proportionately more were occupying full-time academic posts in the United States. The majority emigrated in the decade 1950–9 and were likely to have left within 10 years of qualification. Previous to their emigration 68% were known to be in either hospital or academic posts. Most of the full-time physicians were participating in research, as were nearly half of the part-time physicians.

The questionary was designed to obtain information on the factors which may have influenced emigration from Great Britain. The most frequently stated influencing factors were: (*a*) dissatisfaction with promotion opportunities in the United Kingdom, (*b*) better economic conditions in the United States, and (*c*) dissatisfaction with conditions of work in the United Kingdom. When asked specifically if their decision to leave Britain was influenced by conditions in the National Health Service only half replied in the affirmative. The majority (77.3%) intended to remain permanently in North America and 44% have become citizens of the United States or Canada. It appeared more difficult to obtain a permanent licence to practise in the United States, though this was not usually due to academic difficulties. The most frequently stated problem was that of satisfying State medical board credentials.

Those physicians who have emigrated represent an important intellectual and economic loss to Great Britain, and this is likely, in general, to be permanent. Shortsighted and indifferent Governmental policy in the past has undoubtedly been responsible for much of this loss, and there should be a lesson to be learned and steps to be taken. The alternative will otherwise be a continuing drain on the medical manpower of the United Kingdom, a state of affairs which can be ill afforded. The academic resources that have been lost are major by any standards.

I am grateful to all those physicians who overcame their customary aversion to questionaries, thereby giving me essential information for this article. I would also like to thank the deans of the North American medical schools for their co-operation in supplying information concerning their faculties.

References

Abel-Smith, B., and Gales, K. (1964). *British Doctors at Home and Abroad*. Welwyn, Hertfordshire.
Davison, R. H. (1962). *Brit. med. J.*, **1**, 786.
Last, J. M. (1963). Ibid., **2**, 744.
Seale, J. (1964). Ibid., **1**, 1173.
—— (1966). Ibid., **2**, 576.
Whitfield, A. G. W. (1963). *Lancet*, **2**, 874.