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The consequences of formal study abroad programs on Thai medical doctors: a literature review and research

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THE CONSEQUENCES OF FORMAL STUDY ABROAD PROGRAMS ON THAI MEDICAL DOCTORS: A LITERATURE REVIEW AND RESEARCH PROPOSAL

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URAVADEE CHANCHAMSANG

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Approved by

First Reader _____

Joseph Harris, Ph.D.
Professor of Sociology

Second Reader _____

David Swartz, Ph.D.
Professor of Sociology

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ABSTRACT

Many Thai scholars are skeptical that Thai medical doctors can utilize knowledge and skills in Thailand from experience acquired when they study abroad, due to cultural differences, including a hierarchical culture that places importance on seniority and can prevent medical doctors seeking to actualize those new skills when they return to work in Thailand. Despite growing interest in and study of globalization, there are few existing studies that explore the relationship between social and individual consequences of formal study abroad programs. Nor are there many studies that apply sociological theory on the professions to less developed countries, or that focus on the relationship between power and culture in medical education in Thailand. This thesis will explore these topics by first reviewing and discussing three main bodies of sociological literature on medical professionalization, educational institutions, and study abroad. Given the gaps in the literature, it proposes a comparative study that relies on in-depth interviews with two groups of Thai medical doctors: those who have studied abroad and those who have not. The comparative design will allow the researcher to gain leverage on the consequences of study abroad to individual career trajectories, as well as the broader healthcare system, and contributes to the building of new sociological theory. Despite the many challenges

that Thai doctors who go abroad face in adapting and actualizing new skills, I hypothesize that study abroad alters Thailand's social hierarchy through the creation of a new class of "international doctors," endowed with new skills, knowledge and cultural capital. While the benefits of belonging to this elite class may not be manifested immediately, due to the seniority system, they become apparent over time.

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Chapter 1

Background

Thailand has imported medical knowledge from the United States since the days of the missionary physicians in the 1830s (Becker, 2014) and the Rockefeller Foundation's exportation of medical education. This interaction has since been sustained by Thailand's government and medical institutions sending Thai doctors to study in the U.S. The benefits to be reaped include improved medical education and medical treatment, and a better healthcare system overall. However, some Thai scholars remain skeptical about the results of such a practice. The term *chooptau* is generally used to refer to this endeavor. *Chooptau* identifies the halo effect of improving one's profile or making oneself more valuable by receiving certification and acquiring knowledge and skills that allow one to enhance their own prestige over others (Kangvalert, 1986). In this regard, Thai medical doctors may seek to study abroad as a source of gaining more prestige and higher status back home. Although the doctors who undergo training abroad have the opportunity to gain more advanced medical knowledge, enhance their professional profile, and improve their job prospects, *chooptau* is mainly understood as relating to receiving a degree or certification from a school or institution located abroad. Accordingly, it is worthwhile to research the real meaning of *chooptau* and the exact outcomes gained from studying at medical schools in the U.S.

Thailand is a developing country that greatly depends on Western education in the fields of science and technology, as well as for laboratory equipment. The institutionalization of Western-style medicine, together with other factors, such as power

struggles in the country, has resulted in professional autonomy for Thai doctors, which was encouraged by Western physicians who were in control of medical training (Goldstein & Donaldson, 1979). The Rockefeller Foundation used strategies to create a medical profession in Thailand and founded a new medical school to train a small number of physicians who would provide predominantly Western-style medical care and create a core group to increase their number. This helped to professionalize Thai doctors and further differentiate those who had been trained in universities from those who followed a more traditional healing path.

Following this, the Thai government and the private sector began sending medical students to study in countries such as the United States, Australia, Germany, England, and Canada, a practice that continues to this day. Statistics from the Civil Service Commission (OCSC Thailand, 2015) show that 54 Thai nationals are currently studying medicine in the United States as students, residents, and research fellows—a slight drop from 60 in April 2014. These figures represent approximately 2.5 percent of all Thai students studying abroad, while 15.29 percent of students (354 individuals) are studying engineering (OCSC Thailand, 2015). Although it is certainly true that Thai engineers constitute a larger share of government-sponsored study-abroad program, the overseas training of Thai medical doctors is particularly important because the practice of healthcare is so critical to human life.

Studying and practicing medicine in other parts of the world can greatly expand doctors' understanding of health issues in other countries, expose them to the traditions and beliefs of people from other cultures, and enhance their clinical skills. To fund this

initiative, the Thai government pays an average of $48,940 per student annually. The purposes of the program are as follows: to prepare and develop human resources in the Thai public sector, particularly in updated study areas, so as to serve the changing missions of government agencies; facilitate future social and economic development, and obtain the knowledge necessary to undertake civil service tasks and compensate for the loss of highly competent civil servants; to compensate for the decreasing numbers of scholarships allocated by foreign countries; and to motivate those likely to work for the Thai public sector (CSC Thailand, 2015).

If a trainee does not wish to work for the government after studying, they are required to pay back three times the amount of money that was expended by the government. Doctors must study for one to three years, depending on the program, and work for the Thai government for twice as long following graduation (CSC Thailand, 2015). Researchers have noted that the experience of studying abroad provides students with a learning opportunity that is distinctly different from the traditional Thai academic classroom. Direct exposure to another culture, with its unfamiliar norms and expectations, is highly instructive, especially when combined with another language, and opens up many future career opportunities (Wessel, 2007). In addition, international students gain an acceptance of other cultures, which fosters sensitivity, awareness, and empathy toward others, enabling them to develop capacities, attributes, and values that are appropriate to a global citizenry (Lyons, Hanley, Wearing & Neil, 2012).

These very same opportunities can also pose problems which must be overcome, especially as regards language barriers. The cultural differences may also make it

difficult for Thai doctors to apply to their new knowledge in their native medical setting, as Thai people have very specific cultural attitudes about hierarchy. Social interactions are often hierarchal and defined by patron-client relationships, or *bunkun*, a debt of gratitude, often between young people and elders. Hierarchy is based on age, occupation, wealth and residence; peasant farmers have traditionally been at the bottom of the cultural hierarchy, with merchants and artisans above them, and government officials above them. Variations between individuals and groups in language, religion, culture, nationality, geographic region, and resources negatively impact one's professional status and role in society, as well as the relationship that develops between doctors and patients (Neiterman & Bourgeault, 2015). Despite this, there are still great advantages to participating in study abroad, as doctors who have studied abroad may attain a prestigious position in the Ministry of Public Health, work in a famous international hospital, or become a professor at one of Thailand's respected medical schools, as Thai people believe that studying abroad brings *chooptau.*

This term derives from a well known traditional Thai story called "Sangthong," written by King Rama II of Thailand and can be traced back to the Buddhist literature of India. In the story, *chooptau* refers to the protagonist bathing in a golden pool that causes him to become intelligent and handsome. During the time of King Rama II, Thai students began studying abroad in Europe, England, and the United States. Therefore, this metaphor is used to refer to Thai people, especially those studying abroad, improving themselves in order to attain more prestige.

Medical doctors are almost always viewed as members of the elite due to the

patrimonial structure of Thailand. Those professions employed by the state bureaucracy are seen as part of the succession from royalty and elite officials like medical professionals. Most Thai medical professions are affiliated with large, prestigious government-run hospitals or public medical schools; although there are private hospitals, professionals affiliated with government hospitals have more prestige, wealth and power than those working in the private sector (Maxwell, 1975).

While medical tourism and migration, or brain drain – the migration of doctors and nurses from poorer countries in the southern hemisphere to richer countries in the developed world – have both received a great deal of attention in the literature (Dodani and LaPorte, 2005; Bhumiratana et al., 2009), the effects of foreign study-abroad programs on doctors and their native country's health systems have not yet been studied. Since Thailand has been recognized internationally both for its universal healthcare program – one of the few in the developing world – and for being a destination for medical tourism, with physicians contributing to both projects, this is a particularly interesting area of study.

There are many reasons Thai physicians have for leaving Thailand. The most powerful motives are to update their medical knowledge and the desire for an advanced academic degree. They are also more interested in advancing both professionally and personally, and perhaps having greater research opportunities (Kangvalert, 1986). In addition, statistics reports (Kangvalert, 1986) have outlined some other motives of Thai doctors who come to study in the U.S.: higher academic degree, better work facilities, and higher income. Another influential factor is the better quality of American schools.

However, there are a few problems adapting to living in the U.S., such as the climate and cultural problems.

The experiences that Thai doctors gain from studying abroad may have ramifications not only on the medical training and expert knowledge they receive, but also on the approach to their practice, their understanding of themselves in relation to the broader profession, their career choices and prospects, and the entire health system. This project focuses on the effects on Thai doctors of studying at American medical institutions in terms of the differences between Thailand and the U.S. Specifically, how do doctors adapt when they return home to Thailand? Do they become more professional? How do they react in relation to *chooptau*? Do they become more "cosmopolitan"? Other questions to be examined revolve around what Thai students learn in American medical schools apart from scientific knowledge, and whether there are any differences in terms of interactions between trained medical doctors and professors in the U.S. compared to in Thailand.

Medical Education in Thailand

Founded in 1890, Siriraj Medical School was the first medical school in Thailand. During its first few years, the curriculum included both Western and traditional Thai medicine. However, the different concepts confused both teachers and students, so administrators decided a few years later to teach only modern Western medicine. In the early phase, most instructors came from Europe and the U.S., until the graduates were capable of serving as local instructors. In 1923, through the generosity of His Royal Highness Prince Mahidol of Songkla (His Majesty the present King's father) and the

assistance from the Rockefeller Foundation, a novel curriculum was established to meet international standards. The current six-year curriculum is divided into one pre-medical year, two pre-clinical years and three clinical years (Shapiro et al., 2009).

After finishing medical school, all graduates have to work for the government for three years. The first-year work is mainly in provincial hospitals under the supervision of senior doctors, and then another two years are spent in either provincial or community hospitals. After this compulsory work period, they are free to continue their work in rural areas, move to the private sector, or apply for specialist training. There are also more than 50 residency training and fellowship programs in Thailand and other countries, ranging from three to five years. Apart from these programs, young doctors can also choose to apply for Master's or PhD in medicine.

Some doctors who finish their residency or fellowship program may choose to become professors in public medical schools. Most professors are sent for further study in western countries, particularly the U.S. Thai doctors who study abroad receive funds from public medical schools where they work. Most go abroad for research fellowships because the doctors do not have American medical licenses and it is easier to get accepted to American medical schools; the schools do not have to pay these doctors and they get employees to do medical research. In contrast, Thai private hospitals rarely send Thai doctors to study abroad because it costs too much money, and there is no required service commitment upon returning.

Chapter 2

Literature Review

This research integrates three distinct strands of the current literature: on the medical profession and professionalization of physicians, on educational institutions and the production of inequality, and on medical study abroad.

Professionalization and the Medical Profession

Professional Characteristics and Dynamics

Many sociologists have studied the concept of professions. Durkheim (1893) concluded that professions originally grew because of social integration, which established a foundation capable of creating organic solidarity. From his perspective, the early model of a profession was defined differently from other occupations because it focused on the perceived "function" of maintaining social order. Goode (1960) analyzed earlier literature to synthesize a "professions theory," which defines the three characteristics of a profession: prolonged training in a body of specialized and abstract knowledge; independence or autonomy in one's work; and an orientation toward providing service.

The literature on the medical profession was developed further in the 1970s and 1980s. Freidson (1970), for example, separated two phenomena related to the medical profession. The first is political, related to the granting of a monopoly by the state. The second is social, related to status in securing the public's willingness to support and use professional services. Indeed, public acceptance of the medical profession plays an

important role in the establishment of professional power and status, and the relationship between the state and the market has great influence over medical service and practices. Freidson (1970) further claimed that medical knowledge is specialized and complex, thereby requiring an extended and dedicated learning process, and that consequently non-professionals are unable to evaluate or criticize it.

Some sociologists have emphasized that professions are the result of social structures, powerful groups, and the wider socio-cultural environment (Larson, 1977). The concept of medical authority was envisioned as a combination of cultural and social authority. Cultural authority is defined as the authority to interpret symptoms to diagnose an illness or name a disease, which shapes a patient's understanding of his/her own experience and creates the conditions under which physicians can offer care. This engenders trust, compels obedience, and fosters legitimacy, thereby increasing public dependence on the profession of scientific medicine. Social authority may be considered a result of cultural authority, in that patients are often dependent on their personal physicians after being influenced by their authority. However, the growth of medical authority also needs to be understood institutionally, whereby medical authority regulates the relationships of physicians with each other and the state (Starr, 1982).

Additionally, the relationship between authority, autonomy, and jurisdiction of the medical professions has been investigated. Abbott (1988) analyzed the social dynamics of medicine and concluded that public jurisdiction is a claim of both social and cultural authority. Abbott (1993) attempted to recast his position using three basic arguments: (a) professions cannot be studied individually, but only within an interacting system; (b) a

theory of professions must embrace culture, social structures, and intra-, inter- and trans-professional forces; and (c) the development of professions is necessarily a matter of complex conjunctures.

In a recent review study, Timmermans and Oh (2010) examine three challenges that have arisen in the medical profession, which exemplify the tension between self-interest and collective altruism, including how to act in the best interest of patients: (a) the rise of patient consumerism; (b) the advent of evidence-based medicine; and (c) the increasing power of the pharmaceutical industry. Their results show that these engagements have both negatively and positively affected the quality of medical care for patients. In addition, Martin and colleagues (2009) examined the boundaries between medicine and related professions (such as geneticists), finding that they are defined by power and jurisdiction over knowledge, and that they have a substantial impact on hospitals associated with medical universities – but not on less-prestigious hospitals such as those in rural settings. Moreover, the control of rising medical expenditures by the state has led to highly profitable companies specializing in new medical technologies (Conrad, 1981).

Medical Education and the Socialization of the Doctor

In terms of the professionalization of physicians, Becker (1961) showed that medical professions grow because of many factors. He described students' developing perspectives toward medical school programs by slowly assimilating the perspectives from peers, faculty, hospitals, and clinics. The professionalization of physicians is unique among the professions, with its own specific standards of education and training, and

legally recognized by forms of licensure. However, to consolidate professional power, the medical profession must retain public acceptance, standards of competency, and control over its own membership (Cockerham, 2011).

Indeed, the professionalization process operates under a sort of "cloak of competence," which involves the management of medical students' impressions and the adoption of appropriate demeanor and social codes. In term of socialization in medical school, according to Hass and Shaffir (1977), learning creates a new system of social symbols, and medical students develop powerful, sustained insecurity about the competency expected of them. They learn the medical culture by adopting a professionalizing perspective to meet others' expectations. In addition, students always share experiences in a social context. Professionalization therefore implies multiple commitments – to patients, fellow professionals, and to the institution or system – to the extent that the system supports patients collectively. However, doctors' corporate responsibility, shared as it is with managers and others, is a frequently neglected aspect of modern practice (Wass, 2006).

Hafferty and McKinlay (1993) examined changes in the medical profession in light of the deprofessionalization of medical systems in many countries, such as Canada, the United Kingdom, Australia, and China. They showed that cultural evolution, for example in China, has affected medical practices, and that the Chinese medical system has therefore regained a reputation for professionalism. They also illustrated how the state can distort the ideals of patient care; for example, emphasizing the care of the community over the care of the individual, in the interest of cutting costs, merely

legitimizes the unavailability of complicated care for the elderly.

Conrad (1988) evaluated students during their pre-clinical years and concluded that medical doctors gain excellent medical knowledge and learn the necessary techniques. However, there was found to be inadequate training in instilling humane and caring values, and little emphasis on doctor-patient relationships. In addition, medical students struggle with insomnia, excessive responsibilities, and patient relations. Kleinman (1989) found that medical students use emotion-management strategies to cope with their experiences, which exemplifies the culture of modern Western medicine. In addition, while many medical students want to help patients, others enter medical school with the goal of making money or to gain prestige from their degree. However, students often learn to internalize institutional ethical and moral principles, which are essential if they are to be trusted by patients, colleagues, and the community. They also learn to balance their own emotions with sensitivity toward patients (Cockerham, 2011).

Szymczak and Bosk (2012) examined efficiency training during medical residencies by observing and interviewing internal medicine residents in three training programs. The results illustrate that efficiency has evolved into a social norm that residents use to critique themselves and others regarding work style. In addition, it entails a set of cognitive and interactional skills, including prioritization and anticipation. Also, the ways in which residents are socialized into the medical culture of complex healthcare organizations influences the way they define their responsibilities.

Medical education is bound up with many dimensions of the changing healthcare system. For instance, the payment of costs incurred by doctors' decisions has changed to

a fixed-payment system. This has affected medical education, improved health outcomes, and prevented illness by encouraging research centers to strive for improvement. But medical education is occasionally diverted from its primary purpose, which is patient care. As well, the socialization process creates societal pressures that affect the delivery of medical care; for example, the attitudes and values of people can affect clinical services and faculty research (Light,1988).

The Profession and International Influence of Medicine as a Global Profession

The literature on professionalization in medicine focuses primarily on the U.S. and Western medical professions. But increasing globalization has created a situation in which professional regulators must learn to coexist with powerful national and supranational actors, such as foreign organizations. This situation has significantly altered the way in which many professions are regulated (Starr, 1982; Faulconbridge & Muzio, 2011). The logic of professional development in a particular field has also become increasingly defined in global terms. For example, Dezalay and Garth (2002) explain that there are links between competing groups of elites in the development of international and domestic law. Because of the law's influence in the field of state power, legal transplants are involved in conflict among elites in both exporting and importing societies.

Moreover, international education networks, which encourage elite students from foreign countries to train abroad, have always existed, and American standards of professional practice are routinely used in foreign countries. Therefore, different professional segments and groups seek to assert their authority on particular scientific,

corporate, or political jurisdictions, ultimately transforming the world they claim control over – and their own professional "identity" in the process (Fourcade, 2006).

Other studies have examined variations in the status and role of different professions, such as law and medicine, which has led to the framing of international differences within broader debates about capitalism and market forces (Faulconbridge & Muzio, 2007). There are variations in the knowledge base of the professions and the role of the professions in society that depend on the country. For example, Italian professions acts autonomously to define their knowledge base and training programs. However, in the U.K. and U.S., through representative bodies and negotiations with the state, professions define the knowledge base of the practitioners and the credentials needed to claim a professional title.

The results of both nationally specific priorities and systems of defining knowledge bases reveal important differences in the content and processes of education, in the value of law and medical degrees, and in professionals' culture and values. The autonomy of the legal profession in the U.S. and U.K., for example, has allowed it to develop a close relationship with business over the past century. In contrast, in Germany, the control of professions by the state and the definition, until recently, of professionals such as accountants and lawyers as civil servants have emphasized professional services as forms of technical expertise rather than as value-added commercial resources (Faulconbridge & Muzio, 2011).

In a study related to the medical profession in the global field, Seabrooke (2014) offers the concept of "epistemic arbitrage," whereby professionals such as doctors move

to different countries to gain knowledge and support themselves. The different professional culture in the new country can challenge the existence of ethnic inequality. For example, Lo (2002) studied the Taiwanese medical profession, which is influenced by Japanese values and standards, and found that the profession was closely regulated by the state; however, medical doctors had professional autonomy. Moreover, doctors who live in countries formerly under the influence of Japanese scientific colonialism, such as Taiwan, have a collective identity as medical practitioners and political activists, and Taiwanese doctors adhere to a notion of national physicians distinct from Japanese physicians.

Opportunities in the Literature

The literature on globalization and professionalization lacks specific information on different cultural models of medical education and socialization outside the Western context. With few exceptions, previous studies have focused on medical profession theory and how professions are shaped by various determinants in the West. Few studies have specifically examined the different socialization processes of medical professionals in less developed countries compared to more developed countries. In light of the scarcity of medical expertise and the challenges of transmitting complicated information to new professionals, research on the differences among cultures in medical education is greatly needed.

This research should address what doctors learn from studying abroad, the consequences of their study, and its relevance to their home country, in terms of how new knowledge and skills can be best applied to the unique problems of each

country. Physicians from developing countries who are sent to study in developed countries experience significant challenges because they then must use the knowledge obtained from their experiences in different social and medical situations when they return to their home country. In developing countries, physicians still work in a health system mainly geared toward the treatment of basic infectious diseases, despite the fact that chronic conditions are becoming an increasing part of their total disease burden. Therefore, much of the knowledge that they learn abroad must be adapted to their own setting.

This project will focus on doctors from Thailand, who have a different type of medical training from those in the U.S., and explore the consequences of their studying in the unfamiliar American medical environment. In addition, this project will analyze the cultural effects of these doctors returning to Thailand. The project will contribute to an understanding of how medical knowledge in a specialized field, research skills, language skills, and adaptive behaviors are challenged when doctors are confronted by state power, cultural differences, and professional autonomy.

Furthermore, this study will contribute to the development of the healthcare system and medical education in Thailand, including understanding how Thai medical guidelines are improved or/and changed on the basis of American knowledge, but in ways appropriate to the culture, healthcare resources, and bureaucratic system in Thailand. It will also hold practical value for Thai medical students who are currently in the U.S. completing their training, because it can help them to prepare for the conditions they will encounter back home. Furthermore, this study will contribute to a

new theory that relates globalization to medical education, and the medical professions. It differs from previous studies because it is concerned with how medical professionals in developing countries such as Thailand modify and adapt Western practices, and how the values and experiences gained from studying abroad affect their own individual careers and the broader healthcare system back home.

Educational Institutions and the Production of Inequality

Regarding the sociology of elites and education, many researchers have examined educational inequality through the lens of cultural production. Some studies have addressed the role of schools in establishing symbolic capital in the form of such resources as honor, prestige, and status. Differential access to, and experiences of, education depends on an individual's or group's social position in a particular societal context. Experiences in educational institutions also have an influence on possible future career opportunities.

Bourdieu (1977) claimed that the education systems of industrialized societies function in such a way as to legitimize class inequalities. Success in the education system is facilitated by the possession of cultural capital and a higher class habitus. The dominion of cultural capital is an illustration of how individuals are defined by their embodied, objectified, and institutionalized assets, in addition to their economic wealth and social class. The education system overall has diversified social classes, but it assumes the possession of cultural capital, which makes it difficult for students who are poor to succeed in the education system.

However, some sociologists have argued against Bourdieu's theory. First, Kingston (2001) had two main arguments: (a) cultural capital cannot substantially explain the relationship between social privilege and school success; and (b) there are many omitted variables to educational success that cannot be attributed to cultural capital. For the first argument, DiMaggio and Mohr (1985) demonstrated the importance of cultural capital on high school grades for life opportunities. They found that cultural capital had significant effects on educational attainment, college attendance, college completion, graduate attendance, and marital selection. Their work helped to establish the importance of cultural factors as not just outcomes of elite status but also as explanations for it. Nonetheless, it is difficult to measure the cultural capital of elite family networks (Kingston, 2001). In relation to the latter argument, omitted variables such as a student's own ability and performance do not confirm Bourdieu's theory of cultural production (Kalmijn & Kraaykamp, 1996).

Goldthorpe (2007) has also argued that Bourdieu's view of the transmission of cultural capital as a key process in social reproduction is simply wrong because differing class conditions do not give rise to such distinctive forms of *habitus*, as Bourdieu assumes. Within more disadvantaged classes with little access to high culture, values favoring education may still prevail, and some relevant cultural resources may exist. Therefore, schools and other educational institutions can function as important agencies of re-socialization, not just influence from the creation and transmission of cultural capital.

At the same time, many scholars have built upon Bourdieu's theory, such as Lareau (2003), who found that children from high-income families have an advantage over children from low-income families that lack cultural capital. She observed American children from different social classes and found that affluent parents had high aspirations for their children, so they subjected them to rigorous, structured, and busy schedules of study time and extracurricular activities. They prepared their children for admission to exclusive colleges or universities, where they were expected to succeed. Furthermore, they expected their children, once they were adults, to carry on with this demanding socialization process to govern their lives and, in due course, the lives of their children. By contrast, much less affluent working-class families wished their children well, but had no strict regimen for achieving academic and material success.

Other scholars have argued that elites use culture to define themselves and protect their status. Ostrower's (2002) work shows how elites seek to maintain the exclusive character of their boards and thereby help maintain their status, all while negotiating the demands of institutions that are supposed to be increasingly diverse and open. In addition to constituting themselves and their tastes through such cultural associations, elites create symbolic distinctions between themselves and others in society (Lamont, 1992). Culture is thus a resource used by elites to recognize one another and distribute opportunities on the basis of the display of appropriate attributes. These studies also point out the ways elites fortify their positions by not simply relying upon a single resource to achieve social advantages. For example, administrators of famous colleges frequently look for individuals who will increase their schools' statuses (Stevens, 2007).

Furthermore, in terms of gaining knowledge, Long and Zuckerman (1977) have outlined the logic of status within a knowledge elite class. They studied the stratification of knowledge elites and found that those who won awards were increasingly and disproportionately rewarded later on, resulting in growing disparities between elites and other scientists. Similarly, Lamont (1992) explored the epistemic culture of the academic elite and argued that elite academics not only rely upon their interests, but also what they view as culturally valuable when making judgments. She pointed to the emotional, social, and cultural bases of knowledge and judgment.

One research study by Calarco **(**2014) focuses on cultural transmission and educational inequalities, using observations of and interviews with children, parents, and teachers to investigate how social class differences in children's classroom behaviors contribute to inequalities. The results showed that middle- and working-class parents express contrasting beliefs about appropriate classroom behaviors, and these beliefs shape parents' cultural coaching efforts. These findings are important in that they highlight agency in cultural transmission processes. Scholars of cultural transmission typically rely on top-down socialization models to explain similarities between parents and children. The Calcarco study also revealed a key source of children's class-based behaviors and highlighted the efforts by which parents and children together reproduce inequalities.

Persell and Cookson (1985) examined a private boarding school and found that there were social connections between the school's college advisor and the admissions officers of elite colleges that enabled the former to lobby successfully for some students.

This process thus led to increased inequality in education. In addition, they observed that students entering elite boarding schools in the United States tended to be children of rich and powerful parents. Therefore, when they left these schools, they were already better prepared to for employment. The picture Persell and Cookson present is of a scholastic institution that not only reinforces economic and academic advantages, but also creates an all-encompassing culture in which privilege is assumed and accepted; hierarchical power is thus reinforced in the culture.

Because of the combination of economic and social factors, students from elite backgrounds enter the game with an enormous advantage (Stevens, 2007), and thus often have a better chance of getting into top colleges. Similarily, Karabel (2005) also conducted an in-depth study of the history of Ivy League admissions policies. He found that the elite schools have mainly functioned as clubs where the sons and daughters of the wealthy and otherwise privileged learn their roles of leadership and social ascendancy. Elite colleges hide their admissions policies behind the notion of meritocracy; however, "merit" can mean anything they want it to. Such policies came about only when it became apparent, in the 1960s and 1970s, that preserving elite colleges as fortresses for the wealthy could no longer be obvious. Prior to these changes, discrimination on the basis of race, religion, and economic background was rampant—but it still exists in many forms.

Khan (2011) investigated processes of socialization in elite educational settings in a private school. He claimed that elites have a special way of "being and knowing" and that boarding schools are an excellent place to learn that culture. Social and cultural ease

do not necessarily come naturally to students, and is something that must be learned through the process of socialization. Moreover, cultural aptitudes from people's positions in the world reflect and deepen inequality. With economic inequality dramatically on the rise since the 1970s, educational credentials play an increasingly important role in gaining access to the most lucrative and rewarding careers.

Kenway and Fahey (2014) were interested in how globalization is influencing the social purposes of elite schools. They studied schools in England, India, Hong Kong, Australia, Singapore, South Africa, Barbados, Argentina, and Cyprus—all countries with links to the British Empire. The results illustrated that all the schools had adopted some part of the mentality of the British Empire, and implicated in the economic, cultural, and military dynamics of empire building. Moreover, their research also showed that global connections could help to produce transnational identities, sensibilities, communities, and solidarities with regard to such things as employment, politics, religion, and, indeed, education. Students thus imagine themselves as members of a global high-cultural community. Through non-mother-tongue curricula directed toward international perspectives and cross-cultural understanding, students imagine themselves as cosmopolitan subjects who can competently, comfortably, and with full understanding move effortlessly across and between different locations and cultures.

More recently, Koh and Kenway (2015) examined the leadership-cultivation practices of an elite school using ethnography in Singapore, the United Kingdom, and former British colonies. They focus on the links between the habitus of the Singapore state and that of the school, showing how different components of the school's leadership

function in transnational aspects to produce leaders for the nation. They also looked beyond elite schools as bastions of wealth and the attendant politics of privilege and searched for socialization patterns. Their research illustrates that global educational practices have infiltrated local and national educational systems, practices, and policies. Socialization is thus directed toward improving leadership skills, thereby preparing students for their future social and cultural positions.

Opportunities in the Literature

Many researchers have studied education as an enabler of class and educational inequality, and the educational advantages obtained from being a part of the elite. Some theories have shown that the elite class gains privileges in terms of educational attainment and school admission, particularly to the top prestigious schools. However, no research has explored the effects of the educational privileges received by the elite class on occupational accomplishment compared with those received by the lower classes. In Thailand, individuals who studied abroad are categorized as elites, and to date, no sociological assessment has been made on the elite group that specializes in medical education.

This project will study Thai medical doctors who studied abroad and the advantages they receive when they return to work in Thailand. Do they gain more power and opportunity than those who have not studied abroad? For example, are these doctors more privileged than others in terms of autonomy, access to resources, position, and influence over the medical system in the Thai hospitals where they work? If so, these privileges will stimulate changes in medical education, healthcare, and other relevant policies in Thailand, such as those relating to treatment and other medical guidelines.

Studying Abroad

There is limited sociological research regarding overseas study, but this topic is related to the diffusion of international norms and ideas, which has been a central concern of sociologists for some time. Overseas study is also centrally related to this study's research questions about Thai medical doctors who study abroad.

Studying abroad offers a variety of potential benefits. First, it introduces students to new professors who expose them to new viewpoints and experiences, as well as to a diverse student body that can introduce learners to different customs and cultures. Studying abroad also allows students to expand their academic learning beyond the classroom, as they live what they learn. Interacting with international friends, for instance, improves social skills and enables the exchange of multicultural experiences.

In the research on travel from wealthier to poorer countries, Lasker (2016) found that students and office workers on vacation have varied experiences when they participate in short-term volunteer programs that focus on health services. Her study examined the benefits gained by sponsoring organizations, benefits that can contribute to practices that are inconsistent with what the host country's staff identify as being most likely to be useful and that may enhance the experience for volunteers. For example, students may take advantage of these circumstances to attempt tasks that are well beyond their expertise, while seasoned professionals may cling to standards of practice that are irrelevant or impossible to sustain in poorer countries. Also, unskilled volunteers who do not speak the language may monopolize local personnel with their translation needs without providing much value in return.

Similarly, Barbieri and colleagues (2012) investigated volunteer tourist experiences and noted that exchange students can provide tangible benefits to host communities and local people in varied ways. For example, they benefit the local economy by increasing sales and job opportunities. Furthermore, volunteering internationally can have positive outcomes for both the host countries and the organizations in terms of intercultural understanding.

Yang and colleagues (2011) showed that studying abroad as an active learning process that motivates students to engage in new experiences also enhances their intercultural, disciplinary, career, and personal competencies. Their findings also imply that these students progress personally by developing close relationships with other students and through their experiences in the host country. For optimal student development via studying abroad, students must therefore be encouraged to set intercultural, personal, and academic or career-development goals, and then orient their actions toward these objectives.

Mathers (2010) showed that studying abroad helps students gain a better understanding of their own societies and themselves. She conducted ethnographic research on American travelers, tourists, and students in Cape Town, South Africa, and tracked their movements to and from South Africa to explore questions of American identity and its connection to African ideals. The results are reflected in some travelers' refusal to explore differences related to racism, patriarchy, and hetero-normativity in South Africa. But Africa also became a space to discover what was good about American values and practices.

In addition, studying abroad provides various benefits, including increased international political concerns; greater interest in the arts, language, history, and architecture of different countries; increased foreign language competency; and the ability to see members of various national groups as individuals rather than associating them with non-personal attributes, such as food or geographical characteristics (Kim, 2005). In their study, McGehee et al. (2005) used focus groups to explore possible changes in networks and raise awareness among volunteer tourists. Their findings show that participation in volunteer tourism positively enhances post-trip social movement activities and support for activism. Volunteer tourism also provides opportunities to establish network ties and is a consciousness-raising experience both during and after the volunteer experience. However, study abroad efforts are particularly important in colleges and universities. Thus, it is vital that academic resources are utilized to research the impact and effectiveness of these programs. Pederson (2010) suggested that sending students abroad is not enough without intentional pedagogy focused on intercultural effectiveness outcomes.

There is some existing research that engages with both positive and negative political and economic effects of studying abroad among Thai people. Fry (1984) concluded that possible benefits are: support for political developments such as student democratic revolution of October 1973 (Prizzia & Sinsawat, 1974); the development of new technical skills for national development; increased competency in international languages for professional development; enhanced sensitivity to democracy; and sending money back remittances if they earn money abroad. Overseas study can also be an

important factor in upward social mobility and cross-cultural experiences, leading to positive attitude changes overall (Brislin, 1981).

In contrast, there are negative effects from studying abroad reported by Thai students. First, there may be a lack of foreign exchange in Thailand because students stay in foreign country for long time. Also, students may be more become accustomed to luxury consumption due to the adoption of Western consumer culture. Moreover, the most important negative effect of study abroad is the problem of cultural marginality. When individuals return to their home countries after graduating study abroad, they confront the problem of cultural collision (Fry, 1984). Foreign students learn cultural features in Western countries, but when they return back home they may face difficulties re-adapting to different cultural processes, and may experience marginalization (Lifton, 1970).

Opportunities in the Literature

In short, most of the research discussed in this section speaks to the many benefits of studying abroad, such as the acquisition of multicultural experiences, learning foreign languages, and preparing for a future career. Nonetheless, most studies have focused on volunteer student programs, or volunteer tourism; little research has explored the consequences of formal study abroad programs, especially among professional individuals from developing countries. Moreover, no previous theory has addressed how the experiences and knowledge derived from different cultural practices, resources, and socialization found in developed countries can be used to benefit developing countries, and no research has investigated this topic in relation to medical sociology in particular.

This study will help fill these gaps in the literature.

This research will explore a number of research questions, including the following: Do Thai doctors adapt to changes or encounter struggles when they return home? How do these doctors affect medical education and healthcare in Thailand? The results of this study will garner significant insights by examining U.S. medical institutions that host Thai medical doctors, as well as Thai medical students currently in the U.S.. Through its implications, this study may encourage these individuals to engage in different socialization experiences.

This research is not just a study of overseas work experience; it also focuses on medical education and the effects of studying at U.S. medical institutions. Furthermore, the focus of this project differs from other studies that investigate volunteer tourism, in which travelers participate in voluntary work, typically for charities, with the motive of helping others. Furthermore, most volunteer tourism does not occur in formal institutions or via the government. Overall, this project addresses unique topics in medical education that have not yet been studied within the framework of sociological research.

Synthesizing the Literature

From the literature review above, it is clear that the socialization and professionalization of doctors is unique and different from other careers. Many factors affect this process. They may create a new symbol in medical socialization due to their experiences of studying abroad. Studying medical training abroad bestows many advantages to Thai medical doctors, but can also lead to inequalities due to cultural

differences. Few studies have examined medical doctors in developing countries—especially in Thailand—and the contributions of studying abroad in the U.S.

Hence, this research raises many questions. How do medical doctors participate in socialization during and after studying abroad? What do they learn from foreign medical cultures, apart from medical knowledge? How do they integrate knowledge from the U.S. for use in Thailand? What knowledge do they gain? How does what they learn translate into different career choices, prospects, and their own self-understanding in relation to the broader profession? And what implications do this training have for the healthcare system as a whole?

Hypothesis

The findings from the literature have informed my hypothesis that Thai doctors who train at U.S. medical schools and hospitals gain not only a degree and certification, but also a significant amount of advanced knowledge, research skills, and cultural competency, which helps them become more "international" doctors. Individually, Thai medical doctors who have studied in the U.S. will acquire new experiences that enhance their intercultural skills, disciplinary and career development, and strengthen their personal competencies.

According to Bourdieu, cultural capital is accessed in renowned education institutions and facilitates the acquisition of educational credentials or certifications, but educational credentials are also an important mechanism through which wealth and power are transmitted. Bourdieu's theory of cultural reproduction covers the relationship

between educational attainment and occupational outcomes, but does not engage with the effects of globalization on education. Therefore, the project will fill in this gap in Bourdieu's theory.

My hypothesis is that this group of Thai physicians forms a new social hierarchy and order based on their education credentials, knowledge, and skills from their experiences in the U.S. They also learn a new medical professionalization process that is different from the medical culture in Thailand by adopting a professional image that affords them greater medical authority and the ability to develop a medical practice in a healthcare system in which they can acquire the competencies expected of them. They can gain new cultural capital to develop more power and opportunities than those who have not studied abroad, including more autonomy, greater accessibility to resources, higher positions in their profession, and thus greater influence over the Thai medical system. Studying abroad may also enable them to advance up the hierarchy in Thai medical schools. For example, they will be specialized in specific field to teach residents and obtain higher positions in universities. This power will lead to the creation of new medical guidelines that fit the resources available in Thailand, influence medical education programs, and improve medical research overall.

Despite this, they face the problem of adapting their new knowledge to a different social and cultural climate when they return to Thailand. One of the cultural adaptation problems these Thai medical doctors must confront is the concept of considering others' feelings. Thai cultural norms dictate that doctors should avoid causing other people to worry. If Thai doctors who have trained abroad want to change the Thai hospital system,

their actions will affect doctors and other staff members who are used to the old system. Thai doctors who have studied abroad frequently remain powerfully affected by traditional Thai norms, and they hesitate to change the Thai system. Moreover, although these doctors may gain more privilege and power, they must deal with the traditional hierarchical system in Thailand where younger people have to follow their elders or those who hold a higher position. Therefore, studying abroad may lend doctors more cultural capital, but it does not allow them to rise up the ranks immediately. They still have to confront hierarchies built around seniority.

Thus, my hypothesis is that Thai medical doctors cannot directly and immediately use the medical knowledge they acquired in the U.S.; rather, they need to adapt and integrate it into the Thai system due to different cultural norms and customs. This may be very challenging for Thai doctors who have studied abroad because they have to struggle against the power afforded to elders in the Thai medical system. They thus need to hybridize their knowledge and medical norms to make them applicable in Thailand. This is very challenging because there is no existing theory that explains the resistant relationship between power and culture in medical education and healthcare in Thailand.

Conclusion

There is much literature relating to medical professionalization and the medical profession, educational institutions and the production of inequality, and studying abroad. However, there is no research examining the effects of studying medicine abroad in Western country by those from developing countries. Thailand is a country that has specific culture and traditional hierarchy that governs Thai social life. Therefore, I

propose to study the consequences of studying abroad by Thai medical professions and how they confront their return to Thailand. This work contributes to the building of new theory, drawing on the foundational work of Bourdieu. The next section of the thesis lays out the details of the proposed research.

Chapter 3

Research Proposal

The best way to illustrate consequences of this phenomenon is by comparing those doctors who go abroad and those who do not. Collecting data from Thai medical doctors who have studied abroad can offer information about real experiences both in the U.S. and when they again confront Thai seniority and norms. Conversely, collecting data from those who do not study abroad can provide other perspectives, helping to illuminate any limitations (or possible benefits) that accrue from remaining in Thailand and not studying abroad. Interviews with both groups therefore result in a comprehensive set of comparable data.

Sampling design

This exploratory study involves a sample that includes approximately 20 participants, including 10 Thai medical doctors who have studied abroad, and 10 who have not. Snowball sampling will be used to recruit participants. Participants will be Thai medical doctors who have finished their residency program in Thailand and who are participating in a fellowship research program in any area of medicine. Most have received scholarships from the Thai government, medical schools, or public hospitals for

specialized study in their fields. Participants may not be perfectly distributed equally across medical specialty fields, but care will be taken to try ensure that samples are comprised of doctors from comparable specialties.

Recruits will be drawn from fellowship programs. I chose the fellowship program because doctors in this group influence Thai medical education by virtue of being both doctors and teachers. The program is a full-time training program that focuses on a highly particular specialty, with requirements beyond the related residency. The medical doctors who train as part of the fellowship have to compete with each other in common medical areas, such as cardiology and nephrology, using examinations and interviews. They also play roles in important Thai hospitals because only these schools have the funding to send their doctors to study abroad.

Data

I will collect data through in-depth qualitative interviews. The data will consist of perceptions about medical knowledge before and after studying in the U.S., attitudes toward acquiring new technological medical knowledge, and information on how participants adapt their knowledge for use in Thailand and the obstructions they face when they finish studying in America. In addition, data will include participants' beliefs, insights, and perceptions about studying abroad in general. Table 1 shows the inclusion and exclusion criteria for the sample.

Interviews

Prior to the interview, the purpose of the research will be summarized for participants, who will give their verbal informed consent. Participants will be free to withdraw at any time. I will use Skype or conference calls to interview participants who have finished studying in Boston and have returned to Thailand. Participants will be given pseudonyms, and the recorded audio, which will be stored in a password-protected folder, will use numbers instead of real names to protect participants' privacy and to ensure the confidentiality of the information. Interviews will not be time restricted, but they will take approximately 90–120 minutes per respondent because of the open-ended nature of the questions. Interviews will be semi-structured and will focus on questions concerning how participants were changed by studying abroad.

Table 1. Inclusion and Exclusion Criteria

Inclusion Criteria: • Thai medical doctors who have previously studied abroad in the U.S. • Thai medical doctors who have not studied abroad in the U.S. • Thai medical doctors who are currently studying abroad in the U.S. • Thai medical doctors or students who have received Thai scholarships • Age: 25–60 years • Thai medical doctors who are research fellows or training at clinics • Thai medical doctors enrolled in a program that is longer than 12 months
Exclusion criteria: • Loss of follow-up

The questions will be flexible because the structure of the interview will be contingent upon participants' responses. This will open a dialogue to establish trust and rapport, paving the way for full disclosure. I will first ask introductory questions about the respondents' demographic statistics and then move on to their experiences. The language used for the research will be Thai.

Interview protocol

A copy of the interview protocol, approved by Boston University's Institutional

Review Board, is included below:

To facilitate my note taking, I will record our conversations today. Please sign the consent form. For your information, only the researchers on the project will be privy to the tapes, which will be destroyed upon completion of the research. This interview should last no longer than two hours. During this time, we have several questions we want to cover. If time begins to run short, it may be necessary to interrupt you to push ahead and complete this line of questioning.

Introduction

You have been selected to speak with us today because you have been identified as someone who has studied abroad/not studied abroad at a medical school in the U.S. My research project focuses on the perceived effects of studying abroad on Thai medical doctors. My study does not aim to evaluate your techniques or experiences, but only to learn more about your experiences during your studies in the U.S.

Introductory questions: Interviewees' background

Socioeconomic background

- Could you tell me a little bit about yourself? Where is your place of birth (region/city)?
- What kind of high school did you graduate from (private/public)? What town?
- What are your parents' jobs? Are they medical doctors?
- What level of education did your parents complete? Did your parents live or study abroad? If so, how long were they away for?

- Have you studied abroad or lived in another country? How long were you/have you been (t)here? What program did you study?
- How much is your average household income per year?

Medical education

- What is your specific area of expertise? Where did you study your specialty?
- How long have you worked in this hospital?
- Do you feel there was anything particularly unique that you learned from studying at that particular institution? That particular program? (Omit if n/a)
- Have you ever worked at a private hospital? If so, when and which one? How often do you work there?

Differences between the U.S. and Thailand

- What do you think that Thai medical doctors learn from studying at an American medical school?
- Apart from the medical training in the U.S., do you think there is a special culture that one learns in medical training abroad?
    - Probe: Why do you think the culture is special? How do think it is different from the culture of medical schools in Thailand? In what ways?
    - Probe: Do you think that the broader culture of the United States has influenced the medical culture of the medical school in which you studied? In what ways?
- Apart from medical knowledge, what other kinds of knowledge and learning do doctors who have completed training abroad use?

    - Probe: How is it useful in the Thai medical system?
    - Probe: Have any of those things you learned changed the way you approach the practice of medicine? The way you understand yourself in relation to the profession? Your decision to work in private or public medical practice? How and why? (Omit if n/a)

- Describe your experience of learning to use your authority in Thai medical school? From your experience, were there any differences in the medical culture to which you were exposed in your study abroad? How was it different? (Omit if n/a)
- What do you think was the most valuable aspect of studying abroad? Why? (Omit if n/a)
- What is the most important knowledge that Thai medical doctors who completed studied abroad gain from the study abroad program?
    - Probe: Why do you think it is the most important?
- Do you think that it is difficult for Thai medical doctors to adapt to medical schools in the U.S.? How do you deal with the American medical culture?
- How do you think studying abroad has affected your career choices and job prospects? In what ways? (If doctor has not studied abroad, then substitute "Thai doctors'" for "your")
    - Probe: What factors have most affected your career choices and job prospects? In what ways?

- Do you feel that studying in the U.S. affects the professional opportunities Thai medical doctors who have studied abroad have had compared to those who have not? If so, in what ways?
    - Probe: If so, how do they gain more opportunities in their career?
- Do you feel that Thai medical doctors who studied abroad changed their attitudes or thoughts after returning to Thailand? If so, in what ways?

Limitations

The limitations of this research project include the sample size and location. Moreover, the sampling method (snowball sampling) can cause bias. This study offers an exploratory window into the lives and socialization processes of important yet understudied institutions that play a major role in the professionalization of elites. In addition, it does so for a country that is ripe for study. However, the study's perspective on studying abroad will include only one country. Consequently, the results of the study might not apply to experiences of doctors in other countries. Addressing this problem would involve expanding the field of research to another community. Furthermore, another possible limitation is that conducting qualitative research via in-depth interviews may not reveal social facts if participants do not trust the researcher.

Ethics

This study will conduct qualitative research using in-depth interviews with Thai medical doctors who are studying or have studied at medical schools in the United States. Participants' information will be kept confidential, as it is an ethical imperative to do so

because breaches of confidentiality may harm participants and the trust relationships among the researcher, participants, and other individuals. The processes of data cleansing and gathering informed consent will address the issue of confidentiality. Data cleansing replaces personally identifying information, such as names, with pseudonyms. In addition, audio recordings can be numbered instead of being labeled with names. This study will be approved with permission from the Boston University Institutional Review Board (IRB).

Significance

Intellectual merit:

1. Intellectual discussions: This project will discuss the interactions and consequences of three phenomena: medical professionalization, adaptation to different socialization processes, and studying abroad. For example, how do Thai medical doctors manage their medical authority in the different contexts of the U.S. and Thailand? Morover, this project will also explore how globalization affects medical education.
2. Medical education and healthcare research in Thailand: This project looks in-depth at the outcomes of studying medical institutions in the U.S., and it will contribute to the development of healthcare system and medical education in Thailand. For instance, Thai medical guidelines could be improved based on American medical knowledge.

Broader Impacts:

3. Quality of candidates for studying abroad: This project will reflect on the reasons

and consequences of studying medicine abroad. It will affect or change policies for selecting candidates who want to study abroad in order to match with field of study and better outcomes from studying in America.

4. An improvement of medical practice in Thailand: The project will collect experiences and insights from Thai doctors who will work in Thai hospitals after finishing studying in the U.S. This will help to motivate them to change or improve medical education or healthcare in Thailand, such as changes in guideline or styles of treatment.
5. Preparation for adaptations in different socialization: This project will be valuable for Thai doctors who are currently in the U.S. because it can help them prepare for what they have to confront with working in Thailand. It will also guide them in adapting to different forms of socialization.

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Curriculum Vitae

Miss Uravadee Chanchamsang

Email: uravadeec@gmail.com

uravadee@bu.edu

Education Background:

1998-2003	Triam Udom Suksa Nomklao School, Bangkok, Thailand
2004-2010	Faculty of Medicine, Bangkok Metropolitan Administration Medical College and Vajira Hospital, Mahidol University, Bangkok, Thailand

Skills:

Art Skills:	Electone
Languages:	Fluent in English (Speaking/Writing/Reading)
Computer **:**	Microsoft Office

Academic Experiences:

2009	Research in "Screening Depression in Diabetes Mellitus compared by SDS Score and Department of Thai Mental Health", Family Medicine, Bangkok Metropolitan Administration Medical College and Vajira Hospital, Bangkok, Thailand
2014	Currently studying Master degree in Medical Sociology at Boston University, USA

Student Activities:

2004	Member, IFMSA (The International Federation of Medical Students' Association), Bangkok, Thailand
2004	Participate in 2nd National meeting ,IFMSA-Thailand
2005	Local officer on Public Health, Bangkok Metropolitan Administration Medical College and Vajira Hospital, IFMSA-Thailand
2005	Staff of 3rd National Meeting , IFMSA-Thailand
2005 and 2008	Participate in The Medical Ethics camp, National Council of Thai Medical Students, Thailand
2007	Medical Ethics Committee of Student Association, Bangkok Metropolitan Administration Medical College and Vajira Hospital, Bangkok, Thailand
2008	Medical Ethics Committee, Student Association, Bangkok Metropolitan Administration Medical College and Vajira Hospital, Bangkok, Thailand
2009	Professional Exchange at Geriatric Department, Centre Hospitalier Universitaire (CHU), Poitiers, France

Volunteers:

2005	Volunteer of The Bangkok School for The Blinds (teaching mathematics and science), Thailand
2012	Participate in The Princess Mother's Medical Volunteer Foundation

Work Experiences:

2010	Work as an intern doctor at Srithep Hospital, Ministry of Public Health, Petchaboon Province, Thailand
2010-2011	Work as an intern doctor at Srisangworn, Ministry of Public

	Health Hospital, Sukhothai Province, Thailand
2011-2013	Work as Intern Doctor at Srithep Hostpital, Ministry of Public Health, Petchaboon Province, Thailand
	Committee of Mental Health Clinic at Srithep Hospital, Ministry of Public Health, Petchaboon Province, Thailand
	Committee of Non-Communicable Disease Clinic at Srithep Hospital, Ministry of Public Health, Petchaboon Province, Thailand
	Committee of Hospital Accreditation Team at Srithep Hospital, Ministry of Public Health, Petchaboon Province, Thailand
2012-2013	Seminar in Preventive Medicine, Community Mental Health, Department of Mental Health, Ministry of Mental Health, Bangkok, Thailand
	(December 2012 – March 2013)
2013	Awarded Royal Thai Government Scholarship (Master Degree)

Field of study: Society, Human Development and Health