

Collateral effect of transnational migration: the transformation of *medical habitus*

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Abstract

Objective. To analyze health practice transformations in health providers in Mexico. **Materials and methods.** We used qualitative data to explore transnational health practices of men with migration experience to the US, healthcare professionals in Mexico from eight rural communities, and Mexican providers in US. Data used came from a study that explored transnational health practices in the context of migration. **Results.** Healthcare professionals provided care to migrants through remote consultations or via a family member, and in-person during migrants' visits or by healthcare professionals relocating to migrants' destination communities in the US. The remote consultations mainly caused three changes in the field of medical practice: providing care without a patient review or clinical examination, long-distance prescription of medications, and provision of care mediated by a family member. **Conclusions.** Changes in their medical practice shifted roles of healthcare professionals and of migrants as patients, transforming the hegemonic biomedical model in Mexico.

Keywords: health; migrants; health personnel; professional practice

Resumen

Objetivo. Analizar las transformaciones de la práctica médica en proveedores de salud en México. **Material y métodos.** Se utilizaron datos cualitativos para explorar las prácticas de salud transnacionales de hombres con experiencia en migración a los Estados Unidos y profesionales de la salud en México de ocho comunidades rurales y proveedores mexicanos en Estados Unidos. **Resultados.** Los profesionales de la salud brindan atención a los migrantes a través de consultas remotas o a través de un miembro de la familia, y en persona, durante las visitas de los migrantes o por profesionales de la salud que se trasladan a las comunidades de destino de los migrantes en los EU. Las consultas a distancia causaron principalmente tres cambios en el campo de la práctica médica: proporcionar atención sin una revisión del paciente o un examen clínico, la prescripción a larga distancia de medicamentos y la prestación de atención mediada por un miembro de la familia. **Conclusiones.** Los cambios en la práctica médica modificaron el rol de los profesionales de la salud y los migrantes como pacientes, lo que ha transformado el modelo biomédico hegemónico en México.

Palabras clave: salud; migrantes; personal de salud; práctica profesional

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Transnationalism is an analytical and methodological approach that has contributed to understanding the social processes that occur across borders, where migrants, their families, organizations, and communities can incorporate social and cultural facets, along with information, beliefs, behaviors, and resources from both their countries of origin and destination.^{1,2}

By implementing the transnational perspective, Rivera, based on Levitt's notion of social remittances,³ talks about sociocultural remittances, which are defined as social and cultural goods that circulate between migrants' places of origin, destination, and return. These goods are both: material objects, and practices, values, ideas, and beliefs.⁴

Health-related sociocultural remittances occur in several migratory pathways.⁵ For example, home communities sending medications from Ecuador to migrants in Spain;⁶ the use of medicine from the home country by migrants from southern Africa in the UK;⁷ medical consultations sought during visits to Romania by migrants residing in Ireland,⁸ and consultations via e-mail by South Korean migrants in Canada with dentists in their country of origin.⁹ Mexican migrants in the US also partake in consultations over the phone with doctors from their home communities, and they go to in-person appointments with them during visits. In addition, they self-medicate with products sent to them by relatives or that they buy in the US or in Mexican border towns.¹⁰⁻¹⁴

Migrants face several obstacles to accessing health care services in their countries of destination, such as lacking legal documentation; fear of being reported by providers to migration authorities; being harassed and discriminated against; not understanding the local health system, including long and complicated administrative processes, and language barriers.^{15,16}

Thus, research on health-related sociocultural remittances has mainly focused on the health-related remittances that migrants receive from their countries of origin to take care of themselves. Research on the health remittances migrants transfer back to their countries of origin is therefore scarce, and their impact, unknown.

Certain studies carried out with Mexican migrants have empirically identified transformations in the professional practice of Mexican healthcare providers as one of these impacts. The objective of this article is to analyze the transformations of the biomedical model in Mexico, particularly the medical practice of healthcare providers, caused by health remittances transferred by migrants.

Medical habitus

In order to analyze this transformation of medical practices, we use the concept of *medical habitus*, based

on Bourdieu's concept of *habitus*. The original concept of habitus¹⁷ captures the notions internalized by the individuals that inform their actions. It is built upon the action of the individual, the culture of the group to which they belong, and the social institutions. In this way, *habitus* accounts for and ratifies individual practices, as it is produced and evolves through the interaction between the individual and the social structures.¹⁷ We also utilize Bourdieu's concept of *field* to identify the spaces in which these practices are carried out and the places of occurrence of an exchange of varying forms of capital (economic, such as payments; cultural, such as the value of health, and symbolic, namely: the prestige of greater knowledge and experience).¹⁸ It is Castro who brings these notions of *habitus* and *field* to the space of medical practice, where it encompasses the set of health institutions and actors that maintain relationships aimed at preserving the dominant schemes of definition, perception and appreciation of health practices, including the political, commercial, scientific and professional power that derives from it.¹⁹ The doctor's office serves as an example of a *field* where the exchange of capital takes place between the doctor and the patient. Although these structures replicate themselves without breaches, the fact that, for these structures to be reproduced, they must pass through the individual experience and subjectivity makes them susceptible to transformation.

In Mexico, the hegemonic medical practice has been formed based on the vision of the traditional biomedical model, with a vertical, hierarchical structure.²⁰ However, as we argue in this paper, the process of transnational migration can disrupt this biomedical model through social remittances in health.

Materials and methods

Participants

The data utilized herein came from a study that explored transnational health practices within the context of migration.^{14,21}

There were two groups of participants: males aged at least 18 years with experiences of migration* to the US, and public and private healthcare providers. Participants were from eight rural communities in Mexico from Jalisco, Guanajuato, Puebla, and Oaxaca, and from California, US. These places were selected according to the degree of migratory intensity and

* We considered participants with migration experience as those who have migrated to the US and were living in the US at the moment of the study (migrants) or have returned to Mexico (returned migrants).

the type of migratory region. This was an exploratory project; therefore, we tried to ensure enough diversity and richness of experiences to understand better the studied phenomenon. We included 117 participants in the study: 79 migrants and 38 healthcare professionals (18 practicing in the private sector, 20 practicing in the public sector) (table I).^{22,23} All migrant participants were interviewed in Mexico.

Data collection

The study used a qualitative approach.²⁴ Semi-structured interviews and focus groups were conducted in Spanish and audio-recorded, after participants consented to participate. Interviews and focus groups explored several themes, including: sociodemographic, migratory, and health profile; accessibility and utilization of health services by migrants in Mexico and in the US; the influence of migration on their communities

of origin; changes in the benefits or coverage of health services in relation to migration, and the transnational utilization of healthcare resources and services. Recruitment for focus groups took place in the communities and was facilitated by local authorities, health professionals and other local leaders. Interview participants were recruited at their homes and in public spaces, such as the central plaza; we later utilized the snowball technique. Data collection was conducted between December 2009 and February 2011.

Analysis

All audios were transcribed verbatim by a professional transcriber. Transcriptions were checked for accuracy by listening to the audios. We utilized qualitative content analysis as the analytical approach.²⁵ Transcriptions were coded using Atlas.ti software version 5.2. *Transformation of medical practice* was an emergent category from the

Table I
MIGRATION PATTERN OF SELECTED COMMUNITIES, METHOD USED, TYPE AND NUMBER OF PARTICIPANTS, 2009-2011

State in Mexico	Migration intensity degree 2010*	Migration region [‡]	Type of participant [§]	Data collection method	Number	Total of participants
Jalisco	Medium	Traditional	Migrant men	Focus group	3	16
			Health providers	Semi-structured interviews	7	7
Puebla	High	Centre	Migrant men	Focus group	4	30
			Health providers	Semi-structured interviews	5	5
Oaxaca	Low High	South-South East		Focus group	1	6
			Migrant men	Semi-structured interviews [#]	15	15
Guanajuato	High	Traditional	Health providers	Semi-structured interviews	6	8
			Migrant men	Semi-structured interviews	12	12
California	State with the highest number of Mexican immigrants		Health providers	Semi-structured interviews	9	11
			Health providers	Semi-structured interviews	7	7

* A module on international migration was included in the Census (*Censo de Población y Vivienda*) of 2000 and 2010. The National Population Council constructed the degrees of migratory intensity with information about households receiving remittances, households with migrants to the United States in the last five years, and households with migrants who resided in the United States five years ago and returned to live in Mexico.²²

[‡] In order to study the origin of Mexican migrants, the States of the country have been grouped into geographic regions, which are also related to the different periods of time when massive emigration began in each region.²³

[§] The private doctor's offices were located along the streets in the localities; when it was not possible to identify them, we went to the municipal head and applied the same strategy; public providers were contacted in health centers, and, in order to identify migrants, we toured house to house, went to public places and used the snowball strategy.

[#] Focus group was the main data collection method considered in the study design. Nevertheless, the research group decided to change to semi-structured interviews when we faced difficulties for recruiting participants; this occurred in Oaxaca and Guanajuato states.

original study; for this study, we inductively identified information related with this emergent category only.

All analyses were conducted in Spanish, and quotes for this paper were translated into English after the process was finalized.

This study was approved by the Research and Ethics Commission of the National Institute of Public Health in Mexico (*Instituto Nacional de Salud Pública, INSP*).

Results

We found that public and private healthcare professionals daily provided care for the relatives of migrants and/or the migrants themselves. The healthcare professionals provided health care services to the migrants through: (a) remote consultations; (b) migrants' in-person visits to the healthcare professionals' offices in Mexico; and (c) healthcare professionals relocating, temporarily or permanently, to the migrants' place of destination in the US.

Through migrants and their families, the healthcare professionals were constantly exposed to health remittances from the US. They received information, medicines, and orthopedic and diagnostic equipment, which led to a change in the *medical habitus*. Below are a few examples of these medical transformations, according to the three identified avenues.

Long-distance medical consultations between migrants in the United States and doctors from their towns of origin in Mexico

The migrants and healthcare professionals mentioned that they perform long-distance consultation in two different ways. The most widespread were appointments provided through a relative of the migrant who came to the doctor's office to explain the ailment, received the prescription, and then bought the medication to send to the US. The second most common were appointments conducted via telephone, and, in fewer cases, over the internet, which only the private practice doctors offered.

These remote consultations mainly caused three changes in the field of medical practice. The first is providing care without a patient review or clinical examination. The second is the long-distance prescription of medications, and the third, the provision of care mediated by a family member (table II).

The impossibility of conducting a physical examination led to medical diagnosis based on the information provided by the migrant through their relative. Some doctors warned that there were health problems that could not be identified through this strategy, and they would

ask migrants to complete laboratory studies, and then spoke over the phone once the patient had the results.

A second transformation was observed in cases where private physicians not only prescribed drugs during remote consultations, but also bought and sent them to the US. In some situations, the doctors also sent the prescription, so that the US authorities would allow the medications to enter the country.

The third transformation was that doctors, both public and private, accepted that migrants' relatives served as intermediaries in the consultations. Doctors diagnosed the migrants based on the information provided by their relatives, to whom they also gave the prescriptions, after which the relatives were responsible for sending the medications to the migrants in the US.

In some instances, it seemed that the main motive for the migrants to conduct remote consultations was not so much the medical diagnosis, but rather the need to have access to Mexican medicines. There were cases in which the amount of drugs sent to the migrants was greater than what doctors would usually give to local residents, which could be related to the restricted access to medicines in the US and to the high cost of the shipments (table II).

In-person medical care in the place of origin for those with migratory experience to the US and their relatives

Doctors also provided care to migrants visiting Mexico, and even those who went back specifically for a surgery. Healthcare professionals indicated that migrants were more informed and demanding in relation to health services than non-migrants. Migrants preferred to visit private doctors because they wanted faster care, "more effective" access to drugs, and access to dental care. There were two main transformations that doctors had made to their professional practice as a result of providing care to migrants and their relatives: the demand for laboratory tests, and the adoption of medical technology from the US (table III).

The healthcare professionals explained that in the US, laboratory tests were frequently requested as part of the medical diagnosis, and many Mexican migrants had adopted this practice. Thus, private providers agreed to migrants' requests for tests; an additional factor was that they considered that families with migrants had larger economic income.

Moreover, healthcare professionals were aware of the health care process and the health resources used in the US, through health remittances from the migrants and their families. These were mostly medicines and diagnostic equipment, especially glucometers and barometers, and some orthopedic devices.

Transfer of healthcare professionals from the place of origin to the US for migrant health care

Many migrants and even some US-based companies demanded that healthcare professionals from the migrants' communities of origin be relocated to the latter's places of destination. This resulted in healthcare professionals traveling, temporarily or permanently, to provide medical care to migrants (table IV). This professional mobility is related to an economic rationality in which the healthcare professionals sought to augment their income while acting in solidarity with the migrants, whom they perceived as vulnerable.

There was a variation among these Mexican healthcare professionals in relation to obtaining the corresponding permits from the US government to provide medical or nursing care. Some were certified to work in the US, others did so with a permit, and some worked clandestinely. In the first two cases, the healthcare professionals had access to offices with facilities that met the minimum requirements imposed by the corresponding authorities, as well as to prescriptions. In contrast, clandestine healthcare professionals were limited to clinics without the necessary infrastructure and equipment, providing care in patients' homes, and not being able to issue prescriptions.

Table II

REMOTE CONSULTATIONS BETWEEN MIGRANTS IN THE UNITED STATES AND HEALTHCARE PROVIDERS IN MEXICO

Lack of physical exam in the medical diagnosis	<p>I: <i>Have you noticed any changes in your practice to adapt to migration, such as the need for new skills?</i></p> <p>P: <i>We have to imagine more the pathologies if they tell us about them over the phone: we use a lot the clinical knowledge, not so much the laboratory results or the physical exploration, but more our imagination. We get more questions than from a regular patient, we have to develop a sixth sense to come up with the diagnosis, not through the usual medical devices.</i></p> <p>I: <i>What about the infrastructure of the services?</i></p> <p>P: <i>A lot through internet, phone, fax: these are the most frequently used. For the consultation, we use a lot the fax, fax or internet, to send medical records, or certificates that they came to see a doctor before they migrated; they are asked for it there; otherwise, they will lose the possibility of getting a prescription or of proving that they came to see a doctor.</i></p> <p>I: <i>In some places they are implementing tele-medicine</i></p> <p>P: <i>Yes, a lot through internet; a lot of them send me [images] through video-conference, -Look at this mole.</i> (Private health provider, Guanajuato)</p>
Providers buying and sending drugs to migrants in the US	<p>I: <i>How common is it that they [migrants] talk over the phone with a provider here in Mexico?</i></p> <p>P: <i>In my case, it is very frequent; I am about to withdraw from the bank some money that they transferred, I need to send them medicines. They call me from California, New York: around fifteen, twenty people, some of them asking for advice. Others say, "I would like you to send me this", or some others migrate sick, and, since they know what they used to take in Mexico, they say: "Doctor so and so used to prescribe me this", and they give me names; "Do you want me to send you this?", "Yes", even when it is expensive. [...] I don't charge for the consultation, but they send me money: twenty, fifty dollars, "for your soda". [...] They are the ones that deposit the money; the only thing I ask for is to give me the money for the shipping, because I can't send them a package if they don't give me the money.</i> (Private health provider, Oaxaca)</p> <p>P: <i>They call you from the US and you send them the medication; it is very common: scarcely a day goes by without a person coming to ask for that. [...] It is good business for us to send them the medication, because they do not tell you, "Send me a little box of antibiotics", but "Send me four boxes"; so in that sense, for those of us who own a pharmacy it is good business: you prescribe and sell them medication.</i> (Private health provider, Oaxaca)</p>
Providing care, prescription and medications through family members	<p>I: <i>How do you get the medication in the US without going to the doctor? Or do you necessarily have to go to the doctor?</i></p> <p>P: <i>When you start to get sick, for example with a cold, first you go and look for something that you think could help, and when days go by without you getting better, there are ways to ask for medication [from Mexico], if there is somebody to bring it to you, [...] If not, I tell her [wife]: "Go to see the doctor and ask her to give you medicine for this", and she gives you a prescription [...]. When you run out of medicine you have to use what you have there.</i> (Migrant men, Guanajuato)</p> <p>P: <i>For prevention, the wives [of migrants] are a little bit more careful and, when we find something, they will say things like "You know what? I will bring my husband", or "Send my husband the treatment too." And we provide it to them. The most appropriate would be that they come and to give the medication directly to them, because, if we send it, there is the risk that they may not take it.</i></p> <p>I: <i>What type of medications are the most solicited for family members in the US?</i></p> <p>P: <i>Antibiotics or prescribed-only medication. [...] For example, they know that some infections can be treated with certain antibiotics. Many times, they just come for the prescription, and they buy the medication themselves, although we always advise them to see a doctor first, because it is complicated: there might be patients who have a psychiatric problem, or something of that sort, and who only come to ask for the prescriptions, only the prescriptions; it is rare that they ask for the medication. And the patients who ask us for the medication are generally people for whom we do have a medical record here, and who for some reason are not back [from the US] or something, and send somebody to ask for the medication, either to control their blood pressure, or their blood sugar levels if they have diabetes.</i> (Public health providers, Guanajuato)</p>

Table III

PROVIDING MEDICAL ATTENTION TO MIGRANTS WHEN THEY RETURN TO THEIR HOME COMMUNITIES

<p>Providers are asked to perform laboratory exams</p>	<p>P: When they [migrants] come back from the US and they say, "I want a general check-up, we order lab tests to see how they are. For people from here, I only order lab tests when they need them, because they can't afford them. [Migrants] have more money and want to receive a good service. (Private health provider, Jalisco)</p> <p>P: I had to adapt the way I provide services. They [the migrants] demand what they want in private health services, which should be the way to go, since we are not providing the services for free; if I get a patient from the community with an abdominal pain, I explore him with a stethoscope; whereas they [the migrants] demand to be checked with an ultrasound: [...] "I want an ultrasound to see. So you have to adapt the way you provide the service, such as doing a quick ultrasound even when you know that there is nothing there, so that the patient feels safe. (Private health provider, Oaxaca)</p>
<p>Providers get acquainted with medical supplies and resources available in the US through migrants</p>	<p>P: Respiratory problems are very frequent in children from the US; they bring a lot of medication for allergies, they come with the inhaler revolution —things which are very expensive here—, and they bring a lot of boxes (that is how you start getting acquainted with new medications), and then you look these over on the internet and you increase your knowledge. [...] A person with diabetes gets immediately supplied with their equipment: one device for this, another for that, and as in the US all is fashionable, two months later, they have a new one; so, if they have a family member that is diabetic in Mexico, he gets the new device. The most common devices are for measuring the blood pressure or the blood sugar levels; when someone has emphysema they even bring the oxygen tanks (here there are 4); they also send electric powered wheelchairs. (Private health provider, Guanajuato)</p> <p>P: [In the US] they manage their medications just by the active substance, through laboratories. They fill little bottles and put the name of the patient, what the medication contains and how they should take it. [In Mexico] we use brand medications. I guess it is cheaper [to use active substance medications], because you are not paying for the patents of the medications to the laboratories, just for the active substance. (Public health provider, Guanajuato)</p> <p>P: The glucometers are like cellphones: every fifteen days a new one appears in the market. It is difficult: the device comes with 100 monitoring strips; if they use them all up and the model is no longer available and they can't find the strips, they receive a new one; this is very common. Sometimes, they are shoeless, but if the person is diabetic, they are sure to have their glucometer: their migrant relatives will send them one from there; sometimes they have some that are cooler than mine. (Private health provider, Oaxaca)</p>

Table IV

TRANSFER OF THE HEALTHCARE PROVIDER FROM THE PLACE OF ORIGIN TO THE US TO CARE FOR MIGRANTS' HEALTH AND PRIVATE SERVICES IN THE US

<p>Invitation for the provider to come to the US to provide services</p>	<p>P: I was offered to go to Phoenix three years ago; it was a good salary. An American company wanted to introduce health insurance services for migrants, and a medical professional association came to see me to see if I had completed my degree. They offered me a house, English courses, and to pay for the certification exams in the US as a physician. The only condition was that I needed to stay with that company for ten years; it did not sound like a bad deal. (Private health provider, Puebla)</p>
<p>Mexican private health provider who provides services in the US</p>	<p>I: Why did you move to the US? P: Because of poverty. The town was without population, when I arrived there, I had 25 patients per day; when they moved [to the US], I had only three per week. The people from all the small communities are here, I came following the people. I: What does your medical service entail? P: It is a clinical check-up. I have my prescriptions from Mexico but I can't use them because it is illegal. I write in whatever piece of paper the name of the medication and how they have to take it. It is an undercover medical consultation: in my garage, I have my medical office with the basics, thermometer, stethoscope, blood pressure monitor; I just brought a sterilizer from Mexico and I have equipment for minor surgeries. My limitation is being able to prescribe laboratory tests which evidence clinical experience. Those that can cross the border can go to Tijuana and get the lab tests done there. I know other providers from Tijuana that come over the weekends [to the US], bring medicine, provide care and go back; this is similar to what I do, which is not really legal. I have talked to other doctors that work under the license of another provider. (Mexican private provider, California)</p>

Discussion

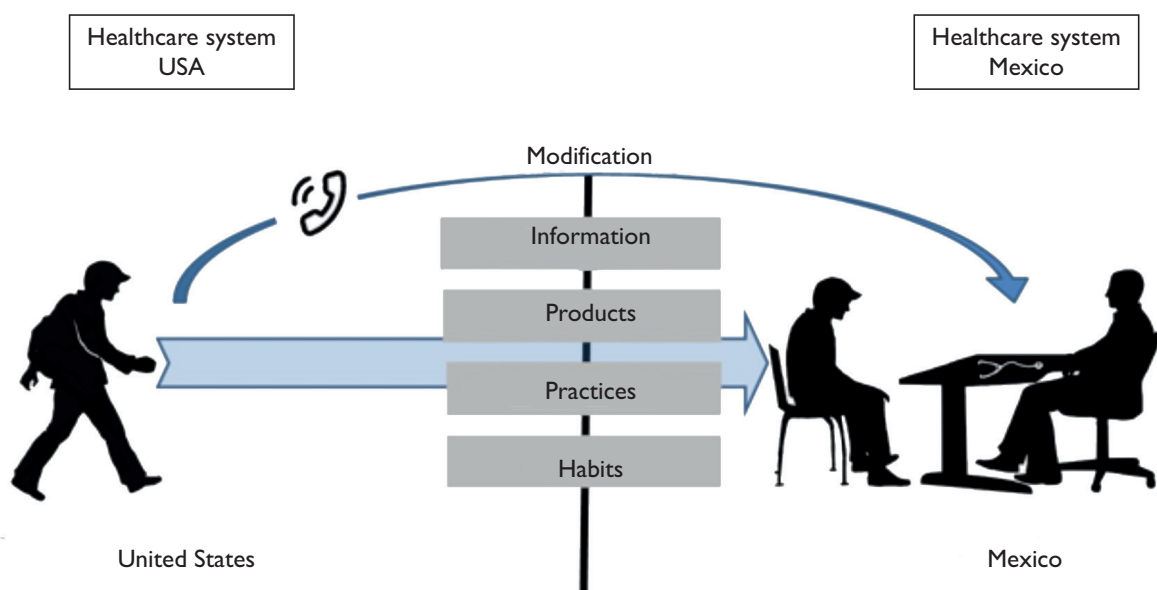
The medical transformations identified in the healthcare professionals' practice in these towns of origin are linked to two fundamental characteristics of Mexican migration to the US. The first has to do with the geographic distance separating migrants from healthcare professionals, leading to different strategies to ensure continued health care coverage, with a key role for relatives. The second characteristic relates to the process through which migrants adopt elements of the US culture and health care system. This phenomenon includes information, products, habits, and practices that are then transferred as health remittances to their towns of origin, including their relatives and healthcare professionals (figure 1). A literature review on the transnational health practices of migrants shows that most studies focus on migrants' behaviors, and, although the health professionals in countries of origin are mentioned, such studies have not analyzed in depth the implications of these behaviors in health professionals' practices.⁵

Of the documented transformations in our study, the greatest implication is for healthcare professionals relocating to the US to provide care to Mexicans, since it involves direct contact with the context in which the migrants live, with the resources and services of the US health care system. This has a greater potential impact on their *medical habitus*, which they normally develop within their own context and with Mexican resources.

From the interviews with healthcare professionals and migrants, we inferred that migrants sought care from Mexican healthcare professionals because of its lower economic cost, the desire for care that they are used to, as well as trust and cultural affinity. As these healthcare professionals become progressively more established in the US, their exposure to US culture and resources increases, as does their knowledge of the situation and context in which Mexican migrants live.

In the practices documented, there is a shift in the doctor-patient roles. The first has to do with the forced omission of physical examination during remote care, with the possible effect of minimizing medical expertise. This breaks the biomedical paradigm, which bases the diagnosis on the spatial location of disease in the body.²⁶ As the patient is not physically present, what is exchanged in the field of the clinic changes, and even the location of the field is modified: since the exchange is now through telephone, internet, or the family intermediary, the doctor's office is rendered dispensable.

Although doctors were often consulted to diagnose a health problem, they frequently served as dispensers of Mexican medicines. Sometimes it was migrants who decided which drugs to be prescribed and sent to them in the US, which involved a second shift of roles. This occurred both during phone or internet-based health care consultations with private doctors, as well as when both public and private doctors were sought by relatives and asked for prescriptions. There were even instances



Source: Prepared by the authors based on the results of the study.

FIGURE 1. HEALTH PRACTICES TRANSFORMATION PROCESS

where private doctors did not charge fees for telephone consultation, since the economic gain came from the service of buying and sending medicines, which rendered this practice a significant source of income.

The third role transformation is private doctors acquiescing to perform laboratory tests on migrants and their families, even if they did not consider them necessary. This situation implies a shift of power dynamics within the medical field, because providers are usually the ones who dictate the rules. Other authors have identified this practice as a form of “social class transformation”, in which migrants use their new economic status to access services to which they have no access in the destination community, and to which they had no access before migrating.^{8,9,27,28}

These three practices show a reorganization of roles and consequently of power, in which the person providing the health service experiences a reduced capacity to make a diagnosis based on their professional expertise; at the same time, as the function of prescribing acquires greater importance, a third function is added which is relevant only within the context of migration: that of buying and sending medicines to the US.

We identify as an additional element powering these changes the knowledge acquired by healthcare professionals about US health system and health resources available in the US. Knowledge is an element of power,²⁹ and in this case, it plays a double, apparently opposite role: it contributes to the transformation of the medical practice and strengthens the professionals' authority (traditional role) in providing services to the local population, whose symbolic value reaffirms its habitus. At the same time, this knowledge weakens health professionals' authority vis-a-vis migrants and their families, since these persons are the main providers of this knowledge, a role that health service users without ties to migration to the US do not have.

Although health remittances and the consultations those migrants and their relatives had with health professionals brought about a transformation of the *medical habitus* of both public and private health care providers, a difference was seen between the two. Public physicians had made fewer changes, as they did not provide care over the telephone or internet, send medicines to the US, or perform laboratory tests on request, as did the private providers.

This could be due to the greater freedom that private doctors have over the conditions in which healthcare takes place, unlike the public providers who, being employed by public institutions, work in spaces with rules and standards supervised by third parties. It may also be due to economic rationality: public doctors have their fixed salary assured, while private ones depend on

patient volume for their wages, which motivates them to perform these practices because of the monetary benefit derived.

This study presents evidence of a transcendent and little-documented process through which healthcare professionals in Mexico are transforming their medical practice as a consequence of their exposure to the health-related socio-cultural remittances brought by migrants in the US and their families. This is particularly true for healthcare professionals living and working in rural communities, who are more susceptible to having their *medical habitus* altered by migration. Research is critical to understand in greater detail the consequences, advantages and risks posed to healthcare professionals, to the Mexican health system, and to the people who use the services of these healthcare professionals.

It will be important to hold debates on this issue in order to avoid prejudices about these practices, and to seek to understand them in depth, with the awareness that they are part of a social process common to many international migration circuits characterized by transnationalism, in which migrants are transforming societies in both their countries of destination and of origin.

Limitations

The transformation of medical practice was an emergent theme identified during the analysis stage, when data collection for a big project was over; if this theme had been identified as the main objective, the information could have been explored at a deeper level, and we would have proposed theoretical saturation of the topic. Another limitation is that the data were collected from 2009 to 2011, and Mexico-US migration has experienced changes since then. Due to the 2008 economic crisis and the increase in deportations during the Obama administration, paired with the increased cost and danger of crossing the border, the net number of Mexicans in the US has stabilized around 11 million.³⁰ Of these, 5.4 million live undocumented.³¹ This subject deserves greater attention within the framework of the new Government in Mexico, where the migratory policies are being redefined regionally.

In terms of access to healthcare services in the US, although the Patient Protection and Affordable Care Act (signed in 2010) reduced the percentage of the population without health insurance from 16%, in 2010, to 8.6%, in 2016, undocumented and temporary workers were excluded from this reform.³² This means that a significant share of Mexican migrants in the US may engage in some form of transnational health practices in addition to border-crossing, including phone consul-

tations or consultations via a family member.¹⁴ In fact, other research has shown that migrants utilizing health services in Mexico are those who have documents to cross back and forth: authors qualified this practice as an expression of class transformation from the migrants' perspective, and a migrant-oriented business health model from the providers' perspective.⁵

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