Activist Roots: How the Care of Political Refugees Forged the Identity of Family Medicine

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November 1, 2025

On April 30, 1975, the last American helicopter lifted from the roof of the U.S. embassy in Saigon. Within hours, 130,000 Vietnamese refugees began arriving at four military installations hastily converted into processing centers[1]. They came with tuberculosis at rates thirty times the American average, with parasitic infections most U.S. physicians had encountered only in textbooks, with war trauma that manifested as blindness and chest pain and insomnia that no diagnostic code could adequately capture[2–4].

This was America at a hinge moment. The Vietnam War had ended in evacuation and defeat. The nation's confidence was shaken, its sense of moral purpose uncertain. No medical specialty was designed for this. A cardiologist could fix the valve but couldn't navigate the resettlement agency, the volunteer translator network, the shared apartment with six other families, and the factory job that meant missed follow-up appointments. A gastroenterologist could prescribe antiparasitics but couldn't address the reality that the pharmacy was two bus transfers away and the instructions were in English. A psychiatrist might recognize trauma but rarely had the language capacity, the cultural framework, or the time to build trust across the distance between Saigon in 1968 and Arkansas in 1975.

The answer, it turned out, would come from a six-year-old medical specialty still defining itself. Family Medicine had been formally recognized in 1969 as a response to the dangerous fragmentation of American healthcare, a system that could perform surgical miracles but

increasingly failed at comprehensive, continuous, and community-based care for whole people. The Willard Report and the Millis Commission, which laid Family Medicine's intellectual foundation, envisioned a specialty that would treat the biological, psychological, and social dimensions of health simultaneously; the question in 1975 was whether they would work in practice[5,6].

Over the next fifteen years, more than a million refugees arrived in the U.S. Federal resettlement policy provided entry but not the infrastructure for integration. And in community health centers from Orange County to Minneapolis to Miami, family physicians - most of them young, barely out of residency - would discover what comprehensive, community-oriented care required.

This essay argues that the refugee crises of the 1970s and 1980s were not merely a challenge for Family Medicine, they were formative. They forced the specialty to operationalize its commitments. As someone who has worked at the intersection of public policy and now medicine, I see this moment as a strategic case study, and the solutions that emerged offer a vital blueprint for today as America faces challenges that mirror the mid-1970s in glaring ways: deep polarization about who belongs and on what terms; mass displacement driven by war, political collapse, and climate change; institutions strained by demands they were not designed to meet; and a national debate about immigration conducted almost entirely at the level of borders and enforcement, with virtually no attention to integration.

Meanwhile, the social fabric that makes integration possible - trust in institutions, capacity for relationship across difference, commitment to seeing strangers as neighbors - has deteriorated. Family Medicine's experience offers a case study in what it takes to rebuild that fabric.

Operationalizing the Biopsychosocial Model

The refugee influx that began in 1975 presented American medicine with a challenge for which the biomedical model, which had dominated post-war medical education, proved catastrophically inadequate. When George Engel published his biopsychosocial framework in 1977, he was articulating theoretically what family physicians treating refugees had already discovered by necessity: that for Vietnamese, Cambodian, and Laotian patients filling their clinics, the biological, psychological, and social were not separate domains to be addressed in silos, but rather a single, integrated narrative of displacement that demanded concurrent attention[7].

The biological challenges alone would have strained any health system. Tuberculosis prevalence among Southeast Asian refugees was 5.8 per 1,000, rates dramatically exceeding that of the general U.S. population[8]. Yet a positive test for tuberculosis was only the beginning of the problem. The real work was ensuring a course of medication could be completed by a patient who spoke no English, lived in overcrowded housing that enabled ongoing transmission, worked factory shifts that conflicted with clinical hours, and feared that missing a day of a new job would mean termination and, potentially, deportation. Intestinal parasites like Strongyloides stercoralis, common in refugee populations, carried the prospect of hyperinfection syndrome triggered by physiologic stress, malnutrition, or medical immunosuppression during resettlement[4,9]. As a result, the ideals championed by Family Medicine's founding documents were a practical and moral necessity.

Beyond the physical ailments, refugees carried psychological distress that exceeded the era's diagnostic categories. The DSM-III would not include Post-Traumatic Stress Disorder until

1980, leaving physicians without adequate language for what they were witnessing[10]. This diagnostic gap was compounded by cultural divides. Hmong patients, for instance, presented with qaug dab peg ("the spirit catches you and you fall down"), a spiritual condition of soul loss that was often misdiagnosed as epilepsy[11]. Physicians saw unexplained paralyses, chronic pain with no organic cause, and blindness that no ophthalmologist could explain.

Confronted with this reality, the family physician's role underwent an unplanned expansion not unlike a one-bedroom apartment turning into a shared home. Treatment plans began to include social prescriptions: "Refer to Catholic Charities for housing," "Coordinate with English tutor at library," "Write note to factory to excuse clinic appointments."[12] The clinic evolved into the central nervous system of resettlement where the physician's authority was leveraged to solve problems far beyond traditional medicine because it was clear that a prescription was useless if the patient was homeless, hungry, or fired for attending a follow-up.

This day-to-day improvisation provided irrefutable proof of concept for the biopsychosocial model at the very moment when the broader medical establishment was finding it "impractical or too complicated."[13] While care systems would continue to struggle for decades with implementing George Engel's vision, refugee care became its laboratory. Yet, this practitioner-level innovation was inherently unsustainable, relying on the individual grit of a young specialty. For Family Medicine to endure, the ad-hoc solutions in the 1970s would need to be embedded into the institutional infrastructure of American healthcare.

Institutionalizing Refugee Care

Throughout the 1980s, the hard-won lessons from the care of Southeast Asian refugees were directly codified into the growing infrastructure of Family Medicine. Federal legislation

created dedicated funding pathways, residency standards formalized novel clinical competencies, and community health centers restructured their delivery models to serve populations whose health outcomes were inseparable from displacement[14]. This demonstrates how health systems learned from crisis, and why those lessons remain applicable to contemporary challenges in health equity and social integration.

In 1975, Congress had authorized Section 330 of the Public Health Service Act that funded community health centers in neighborhoods across America. These were designed to serve the medically underserved: low-income communities, rural areas, and migrant populations. Unlike traditional fee-for-service primary care, Section 330 health centers received federal grant funding that allowed them to operate regardless of patients' ability to pay, allowing them to invest in staff, interpreters, and social services alongside medical care. By 1980, this infrastructure existed but was fragile, underfunded, and struggling during the Reagan era[15].

Then the Refugee Act of 1980 created a new funding stream specifically for refugees. It authorized federal reimbursement for refugee medical assistance during initial resettlement alongside grants for refugee health screening and treatment administered through the Office of Refugee Resettlement[16]. Critically, this new refugee funding could be layered onto existing Section 330 health centers. This dual financing created new capacity such that centers could now support language access, mental health services, and legal aid, all prerequisites for effective care.

Concurrently, the Health Professions Educational Assistance Act of 1976 reoriented federal training priorities toward primary care workforce development explicitly targeting underserved populations[17]. By the mid-1980s, family medicine residencies in high-immigration regions were already formalizing cross-cultural training linked to community health clinics.

Cultural competence moved from abstract concept to curricular expectation, and increasingly programs published curricula to operationalize it[18,19].

The efficacy of this newly built scaffolding was tested almost immediately by new geopolitical ruptures. However, the response to new groups was markedly different from the panic of 1975. Where the initial Vietnamese arrival was defined by improvisation, the response to groups, while still immensely challenging, was more systematic. Public health protocols for disease screening and management were more robust. Mental health triage, informed by the recognized trauma of the Vietnamese experience, was more anticipated. Family Medicine did not just become better at caring for refugees; it began to redefine the physician's identity, transforming the healer into an advocate whose work in the clinic was inseparable from the political realities that brought the patient there.

A Blueprint for Belonging

The institutional scaffolding built throughout the 1980s provided Family Medicine with a stable platform. But it was the application of these lessons to contemporary challenges that reveals the specialty's most enduring contribution. What family physicians discovered between 1975 and 1990 was that restoring health required rebuilding the connective tissue of fractured communities.

The concept of the "body politic," the nation as a living organism whose health depends on the connection of all its parts, captures what those practitioners witnessed. Refugees avoided care due to fear. Communities had lost trust in medical institutions along lines of language, documentation status, and trauma.

Today, America exhibits symptoms of this pathology at unprecedented scale. Over 100 million Americans live with chronic disease, yet 25 percent of adults lack a regular source of primary care[20–22]. Despite spending 17.6 percent of GDP on healthcare ($4.8 trillion in 2023), life expectancy has stagnated below pre-pandemic levels while maternal mortality climbs beyond peer nation rates[23–25]. More primary care clinicians leave the workforce annually, and projections show a deficit of nearly 90,000 primary care physicians by 2037[26]. But the crisis extends beyond workforce numbers. Public trust in health institutions has declined, partisan differences in vaccine acceptance and clinical guidance adherence have reached historic magnitudes, and fear of immigration enforcement deters healthcare seeking among many[27–29]. The clinic, historically a space where partisan identity was irrelevant and shared vulnerability created common ground, has become contested terrain. The ability of Americans to see themselves as members of a shared body politic, to recognize that their health is interdependent with that of neighbors regardless of immigration status or political belief, is fragmenting. It is this context that Family Medicine's history with refugee care offers lessons in what it takes to rebuild that fabric.

Back then, the difference between thriving and suffering was not determined primarily by individual resilience or ambition, but by whether health systems, resettlement agencies, employment services, housing programs, and educational institutions were intentionally coordinated to support newcomers. Family physicians learned through improvisation that biomedical care alone was insufficient. A tuberculosis-free Vietnamese refugee who could not find work remained economically excluded. A trauma survivor without access to mental health services and legal support remained socially isolated. The clinic had to become the nucleus where all systems interfaced.

Longitudinal data confirm this. Refugees with access to integrated services achieved increased household incomes and homeownership. Those without such services experienced chronic unemployment, higher hospitalization rates, intergenerational poverty, and social exclusion. Yet today, refugee and migrant health infrastructure are still fragmented. Medical screening, mental health services, employment programs, housing assistance, and legal aid operate through separate federal agencies with different eligibility rules and funding streams.

The path forward could involve "Integration Health Hubs" as critical federal infrastructure. These would co-locate primary care, behavioral health, legal counsel, employment specialists, housing navigators, and language access across physical and digital platforms. Economic analysis demonstrates that upfront investment yields downstream cost savings through reduced emergency care utilization, prevented hospitalizations, improved chronic disease management, increased tax revenue from employment, and dramatically reduced reliance on public benefits. Furthermore, what family physicians discovered in the 1970s was that their power derived from the trust they cultivated with patients and families. This trust has now corroded, and restoration requires that health data be better protected in the face of emerging threats. Electronic health record systems must also become more interoperable with greater sharing between previously siloed entities. We have the capability to achieve these aims; in 2025, technology is enabling us to track mental health presentations, food insecurity, housing instability, and employment status in real time. At national scale, aggregated data from primary care clinics could map social determinants and target federal grant and workforce resources toward emerging crises before they metastasize. This requires investment in data infrastructure and training family physicians in public health communication. But the return is transformative:

the family physician steps into the role of translator, converting patients' lived experience into evidence that informs democratic governance.

What the refugee crises of the 1970s and 1980s revealed was not that Family Medicine could adapt to extraordinary circumstances, but that its founding commitments were designed for precisely these moments when the social fabric tears. The young physicians who cared for Vietnamese, Cambodian, and Laotian refugees were not departing from their specialty's mission; they were fulfilling it. They proved that medicine practiced at its fullest is inherently activist work: advocating for patients against systems designed to exclude them, building trust across chasms of language and trauma, creating infrastructure where none existed, translating suffering into policy change.

Those models endure as blueprints for the crises America faces now: crises of belonging, of trust, of whether we can see ourselves as members of a shared body whose health depends on all its parts. Family Medicine's activist roots established the clinic’s place as democracy's most vital organ where values of equality and dignity become concrete in the doctor-patient encounter. The specialty's contribution is showing how to rebuild the bonds that make us whole in an era when those bonds are fraying. That lesson has never been more urgent.

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