The Dissertation Committee for Wasudha Bhatt certifies that this is the approved version of the following dissertation:

RACIST MEDICINE AND CONTESTED CITIZENSHIPS

Migration of Indian Physician's to the United States and the Paradox of Return

Committee:

Bryan R. Roberts, Supervisor

Nestor P. Rodriguez, Co-Supervisor

Mounira M. Charrad

Kamala Visweswaran

Tetyana Pudrovska

RACIST MEDICINE AND CONTESTED CITIZENSHIPS

Migration of Indian Physician's to the United States and the Paradox of Return

by

Wasudha Bhatt, B.A., M.A., M. Phil.

Dissertation

Presented to the Faculty of the Graduate School of

The University of Texas at Austin

in Partial Fulfillment

of the Requirements

for the Degree of

Doctor of Philosophy

The University of Texas at Austin

August 2013

Dedication

To my parents… for being the wind beneath my wings.

Acknowledgements

Sometimes acknowledgements can never be adequate in reflecting the gratitude one might feel towards ones mentor. Sometimes there are so many things that you are grateful for that one does not know where to begin and where to end. Sometimes deeds overpower all narratives one might attempt to write. I refer here to my wonderful journey with Professor Bryan R. Roberts that I was blessed to be a part of. Thank you so much Professor Roberts!

I am and always will remain deeply indebted to Professor Nestor P. Rodriguez for his kindness, generosity, compassion, devotion, enthusiasm and commitment for this research and as my supervisor.

I am most grateful to members of my dissertation committee: Professor Tetyana Pudrovska, Professor Maya M. Charrad and Professor Kamala Visweswaran for their invaluable inputs and comments in helping me think through and put together this research.

My deepest gratitude to all the physicians interviewed for this study who took out time from their tight schedules to share their thoughts on this subject with me. Without their generosity of spirit and courage to be forthcoming and honest, this research would not have been accomplished.

I would like to thank all my colleagues at Austin, particularly David Watkins, Carlos Díaz-Venegas, David Glisch-Sánchez, Jane Ebot and Bob Sitko for being a great source of encouragement, support, and strength for me.

Thank you would be a very small word for Aun Ali, who was supposed to be my student mentor for the first year at the University, but mentored me way beyond it. Thank you so much Aun for being YOU.

A special thanks to my husband who has been the most selfless, enthusiastic and stimulating companion I could have wished for in the course of this research.

Finally, I am grateful to Vidushi and Anirudh for infusing this journey with eternal sleep debt, joy, love and hope.

RACIST MEDICINE AND CONTESTED CITIZENSHIPS

Migration of Indian Physician's to the United States and the Paradox of Return

Wasudha Bhatt, Ph.D.

The University of Texas at Austin, 2013

Supervisor(s): Bryan R. Roberts; Nestor P. Rodriguez

In American medicine, research has consistently shown disparities between the health experiences of non-Hispanic whites and minority groups (Shervington, 2000); but the practice of racial discrimination *within* the medical profession is less well acknowledged. Unlike other professions, medicine is a person-oriented field, where Indian physicians are susceptible to facing discrimination on a daily basis. My in-depth interviews with 108 Indian physicians show that individual physicians may achieve social mobility and gain economic parity in the United States, but only as exceptions to the rule, as evident by racial discrimination in

promotions, referral patterns, and the ‘glass ceiling’ faced by them ‘when it comes to really rising to the top’.

Moreover, the social incorporation of Indian physicians is itself tied to paradoxes and discontents, when minority group members are not fully accepted either by the dominant group or by their own ethnic community. It is in this context that I seek to analyze the influence of social interactions at work on the social incorporation of first and second-generation Indian physicians and in determining their workplace experiences and migratory outcomes.

Likewise, with the effects of discrimination being greater for men than for women, the existing gender inequalities in American medicine have differential impacts on the workplace experiences of Indian men vis-à-vis women. However, much of the production of gender and racial inequalities in organizations at large (Acker, 2006) and particularly in medicine, have focused on one or another of these categories, seldom attempting to study them as complex, mutually reinforcing or contradicting processes. My dissertation research strives to make this dimension a crucial part of the analysis.

This study should contribute to our understanding of the interaction of recent migration of skilled personnel with developing

racial/ethnic and gender relations in US workplaces. The healthcare workforce in the developed world has become increasingly dependent on immigrants from the developing world. I see addressing issues of racial and gender bias in American medicine as a priority in the social sciences and a necessity for a holistic healthcare system in the 21st century. My research is an effort in this direction.

Table of Contents

List of Tables

List of Figures

Chapter 1

RACIST MEDICINE AND CONTESTED CITIZENSHIPS

Migration of Indian Physician's to the United States and the Paradox of Return

INTRODUCTION

This dissertation takes up two related and apparently contradictory issues. One is the brain drain of Indian physicians to the United States, who unlike their fellow professionals in engineering rarely return to India. The other is their experience of discrimination in the US medical labor market, which does not, however, make it more likely that they will return home. I explore the new (medical) environment of racism and gender discrimination produced by a new visa category (H-1B and J-1) for high skilled nonimmigrant (temporary) workers in the United States, when contrasted with discrimination against second-generation physicians of Indian origin. I look at how the presence of these nonimmigrant (temporary) workers from abroad who are racially different affect conditions of inter-racial interaction in U.S. medical workplaces, particularly when compared to their second-generation counterparts. I consider why physicians who emigrate from India stay in the United States despite the racial discrimination that they encounter. I use first and second-generation Indian physicians own accounts of their reasons for migrating and settling in the US. I also explore their experiences of discrimination by other physicians, patients and

medical institutions, what I call ‘racist medicine’. I will look at the way the experience of discrimination differs for men and women and includes the internal antagonisms within the Indian origin medical community between first and second-generations and between different castes. Discrimination is also multi-layered, based not only on race, but also on religion and accent.

Brain drain accompanying the emigration of skilled labor force is widely perceived to be detrimental to the development of developing countries (UNCTAD, 2007). Studies show that a large number of the brightest skilled workers in developing countries often end up emigrating to the developed countries where they experience an enormous increase in their wages and quality of life (Clemens, 2009). However skilled emigration has an adverse effect on the economic growth and productivity of the sending countries. It deprives the left behind of their professional expertise, results in lost educational investment to the nation, skews income distribution, and hinders the creation and adoption of new technologies (Aitken, 1968; Bhagwati and Hamada, 1974; Clemens, 2009; Lucas, 2005). As a result, “departure of the most productive and highest-earning workers lowers average income of the whole country, and forces skilled workers’ wages at home so high that stayers overinvest in skill—leading to the waste of unemployed professors, engineers, and doctors” (Clemens, 2009:5).

This brain drain of human capital and its after effect are most pronounced and visible in the Indian health sector. Among the high-skilled immigrants, it is the physicians who are regarded as 'one of the most expensive professionals to train' (Portes, 1976:497). It is the superior medical training imparted to doctors in India that largely prompts physician emigration from the country. They find that comparable opportunities and infrastructure to either put their training into use or acquire advanced training in sub-specialties is either lacking in India or concentrated only in large urban cities where there is already an overflowing physician population in medical colleges and the job market. The United States constitutes the most favored destination for health professionals from India (Khadria, 2004), despite the racial discrimination that Indian physicians encounter in U.S. medicine. In fact Indian medical schools supply the largest number of foreign medical graduates to the United States (Kumar and TB, 2007). So much so, that after native-born U.S. physicians, 'there is one Indian doctor available in the United States for every 1,325 Americans in contrast with one Indian doctor in India for over 2,400 Indians' (Adkoli, 2006:52).

Migration of Indians to the United States began as early as the 1790's when young Indians were employed at the India wharves at Crownshield and Derby, two of the larger shipyards. 1880's further witnessed a few hundred Indian traders entering the United States to trade in linen, silk, spices and other goods from India (Koritala). However, it is in the 1900 that the first Indian immigrant is officially recorded to have entered a U.S. port (Chandrasekhar, 1944).

Subsequently a number of Indians largely from the Indian state of Punjab, migrated to the West Coast, essentially California, working mainly in the logging, railroad and agricultural industry (Bhattacharya, 2008). Racial discrimination against these early immigrants soon followed due to the competition they posed for the native population, by working for longer hours and lesser wages (Khadria, 1990). Consequently, their numbers declined, as they were largely restricted from entering the United States after 1908 and were admitted just occasionally till 1916 by U.S. immigration officials (Chandrasekhar, 1982; Fisher, 1980; Hess, 1974; Minocha, 1987). The 1917 Pacific Barred Zone Act with the 'geographical delimitation clause' regarded certain countries as 'unfit to send immigrants to America,' and prohibited Indian immigrants from entering the United States on a permanent basis (Chandrasekhar, 1944:141).

It was with the Immigration and Naturalization Act of 1965 that Indian immigrants were finally granted entry into the United States. With their visa limit extended from 100 to 20,000 per year, immigration of Indian professionals to the United States increased by more than 400 percent from 600 in 1965 to 2,500 in 1966 (Gupta, 1997; Khadria, 1990). 83 percent of the Indians who immigrated between 1966 and 1976 were a select group of high skilled urban-educated professionals with scarce skills, who were able to relatively withstand occupational discrimination despite having to encounter the glass ceiling (Dutta, 1981; Gupta, 1997; Takaki, 1989). This period marked the beginning of an active brain drain of professionals from India to the United States, a flow that was only

going to increase in the years to come. In fact in the year 2010, 69,162 legal permanent residents in the United States had listed India as their country of birth, just after Mexico and China (Monger and Yankay, 2011).

THE DYNAMICS OF SKILLED INTERNATIONAL MIGRATION

Portes (2009) argues that information-driven developed nations compensate for their dearth in technical and professional native-born talent by complementing it with imported foreign trained high skilled labor force. It is the political and economic disparity between the core and peripheral countries, which is largely responsible in conditioning the brain drain of skilled professionals (Portes, 1976). In fact dependency theorists perceive professional emigration as another route by which the capitalist countries at the center extort resources from the countries in the periphery (Frank, 1967; Santos, 1970). Oteiza (1967) identifies four differentials in the socioeconomic organization of the advanced and developing nations that promote brain drain of high skilled workers: '1. An income or economic differential between the amount and security of remuneration for professional labor in advanced countries and in less developed ones. 2. A logistical support differential between the equipment, staff, funds, and general facilities for research and practice in advanced and less developed nations. 3. A prestige differential in the status accorded scientists and professionals between the two types of societies. 4 A residual differential covering such issues as political instability and threat of repression versus social peace and relative political freedom' (Portes, 1976:492). Portes (2009) however

attributes the brain drain of high skilled professionals to the ‘relative deprivation’ that they experience in their home countries, that compels them to emigrate because of the better work conditions abroad (Alarcon, 1999). This promotes ‘structural imbalancing’ between the developed countries and nations that are still on the path to development by preventing them from preserving their domestic labor force (Portes, 2009; Portes and Walton, 1981; Sassen-Koob, 1988). Portes (2009) argues that most developing countries aiming to modernize along the western path, train their professionals according to western standards; but they are unable to create comparable opportunities to absorb their trained manpower. This in turn creates and contributes to the ‘relative deprivation’ experienced by these trained professionals who in turn seek their professional outlet by emigrating to first world countries like the United States that are already short of high-skilled domestic workers. This could be partly attributed to the fact that the immigration policies of developed nations are often geared towards selective tapping of professional migrants. This helps make up for the shortage of technical personnel in medicine and other such fields as is demonstrated by the “preferred immigrant” criterion of the U.S. Immigration Act of 1965 (Justice, 1970; Portes, 1973; Segal, 1991).

The demand for international medical graduates in the United States particularly mirrors this need for foreign trained physicians partly because of the reluctance of U.S. graduates to opt for lower-paying primary care specialties and in part because of the anticipated increase of 53 percent in the number of senior

citizens by the year 2020 who will need healthcare in the United States (Brotherton and Etzel, 2010; Ebell, 2008; Kumar and TB, 2007). It is in recognition of this need that the U.S. Congress extensively revised the H-1B visa program through the Immigration Act of 1990 by giving temporary visas to foreign medical graduates for entering medical residency and fellowship programs and to engage in patient care (Kumar and TB, 2007). Although the H-1B visa is issued for periods normally not to exceed three years, and renewable for three more, “in practice, many ‘H1B workers’ eventually manage to shift their status to permanent residents” (Portes, 2009:13).

The J-1 visa under the ECFMG exchange visitor visa program offers another route to foreign medical graduates to pursue advanced training in medicine and also work in the United States for a maximum of seven years (Report, 2007). Foreign graduates under the J-1 visa program are usually required to return to their home countries for two years after the completion of their seven-year term, before they can apply for permanent residency or convert their status to an H-1B visa holder. But most of these physicians actually end up converting their visa status to that of an H-1B specialty worker through the J-1 visa waiver program. The foreign residency requirement waiver is usually obtained in exchange for an agreement with the concerned government agencies that the concerned physician practices primary care in a federally designated health professional shortage area or a medically underserved area for at least three years (Health, 2011).

From the perspective of brain drain, emigration of Indian physicians has resulted in a profound loss of highly qualified professionals for India. Although comparative studies on return migration of health professionals are scarce, scholars argue that return of high skilled workers is discouraged because of their greater than before quality of life and living standards after migration (Clemens, 2009). Research on the All India Institute of Medical Sciences (AIIMS) which is India's premier medical school located in New Delhi, shows that 56% of the physicians from AIIMS emigrated during 1956 to 1980 (Adkoli, 2006); as did 54% of the 1989–2000 graduates, 85.4% of whom emigrated to the United States (Kaushik, Jaiswal, et al., 2008). And among the 1996–2000 AIIMS graduates 'only one of the emigrating AIIMS graduates returned to India and that was for just 1 year' (Kaushik, Jaiswal, et al., 2008:42). Return is critically affected by the 'initial motivations for migration as well as by the duration of the stay abroad and particularly by the conditions under which the return takes place' (Cassarino, 2004; Ghosh, 2000a:185). Research shows that the rate of return of Indian physicians from the United States is low (Kaushik, Jaiswal, et al., 2008; Kaushik, Roy, et al., 2008) despite the professional discrimination that they encounter. Considering the immense impact that return of Indian physicians from the United States can have in enhancing and contributing to better health outcomes for India, more research is needed to understand what factors deter return and differentiate physicians who stay back from the returnees.

Earlier research on this subject has identified a number of critical issues that confront undergraduate and postgraduate medical education in India including the lack of infrastructure and resources to provide meaningful and satisfying professional experience. In addition there are complex issues such as region and caste that may have significant influence in an individual's decision to stay in India versus immigrate to another country. However, prior observations are largely based upon analysis of publicly available datasets whereas detailed qualitative data addressing the reasons for migration are limited. Given the limitations of prior data, assessing the relative contribution of these factors is difficult. Furthermore, there is paucity of available data on the impact that immigration has in the lives of first-generation Indian physicians residing in the United States, a limitation that I seek to remedy in this dissertation.

RACE, GENDER, AND THE DIFFERENT BASES OF DISCRIMINATION IN AMERICAN MEDICINE

Studies on the social and economic incorporation of new immigrants in the United States have by and large categorized them into two distinct immigrant streams of high and low-skilled immigrants. High skilled workers armed with the required skills are believed to experience 'substantial economic and residential mobility' when contrasted against the 'slower progress' of labor migrants (Alba and Nee, 1997:864). But what is often overlooked is the 'extra effort and household strategies' that Asian Americans are compelled to employ for overcoming 'continuing discrimination, and the costs of that effort' (Caplan, et al.,

1989; Espenshade and Ye, 1994; Kibria, 1994; Waters and Eschbach, 1995; Yamanaka and McClelland, 1994:435). Intergroup contact and incorporation in the United States, resulting from the emigration of skilled professionals from developing countries is resulting in new conditions and practices of racism and sexism. Even in professional positions that require advanced training, mobility ladders do remain difficult and are colored by racial and gender hierarchies. This could be ascribed to 'discrimination in the higher end of the occupational structure (the glass ceiling effect)' particularly as 'unobservable human capital differences in things like quality of schooling or English language skills' (Waters and Eschbach, 1995:433) do not apply to second-generation physicians of Indian origin. Unlike prevalent beliefs, Indian immigrants of color and their second-generation counterparts need to build their professional identities against the backdrop of racial and gender hierarchies that remain pervasive and regulate their social mobility and occupational structuring in the United States, despite their high-status skills. However, research in the United States on racial discrimination against Asians has focused on traders and in terms of class competition (Kim and Sakamoto, 2010; Sethi, 2003). Class competition is less relevant to physicians of Indian origin in the United States, who comprise one of the highest paid professional groups in the world.

Studies investigating the biases and barriers faced by Asians and other minority physicians in American medicine testify to the prevalence of discriminatory outcomes. In one such study, 45% of practicing Asian physicians

reported to have experienced racial or ethnic discrimination ‘sometimes, often, or very often’ in medicine (Nunez-Smith, et al., 2009:1198). In the same study, 39% of practicing Asian physicians reported to have experienced ‘discrimination in their current work setting’ (Nunez-Smith, et al., 2009:1198). When it came to rank advancements, studies found that in 1989, it was only after 3 to 7 years later compared to whites that minority faculties were promoted to the rank of associate professors (Petersdorf, et al., 1989). Research shows that even after adjusting for sex, degree, type of medical school, cohort, tenure status, department and receipt of National Institute of Health awards; the promotion rates of Asian assistant professors in U.S. medical schools are lower relative to whites (Fang, et al., 2000). And an Asian faculty is 42% less likely to hold a senior rank of associate or full professor when compared to a white faculty (Palepu, et al., 1998). Moreover minority faculties in general are less likely to reach associate or full professorship than whites, even after adjusting for academic productivity or years as a medical school faculty (Palepu, et al., 1998). In another study 26% of non-underrepresented minority (NURM) faculty in U.S. medical schools acknowledged to have lower career satisfaction than other faculties and reported to have been racially/ethnically discriminated by colleagues or supervisors, despite achieving comparable academic productivity and senior rank promotions to other faculties (Peterson, et al., 2004). Recent research also suggests that racial or ethnic disagreements between students and their mentors may create new challenges for ethnic minorities (Thomas, 2001; Wright and Carrese, 2003).

In addition to race, socially categorized indicators such as gender, migrant status, accent, and religion/nationality play an important role as the possible bases of discrimination and prejudice against immigrant physicians, and their second-generation counterparts in professional settings. For instance, organizational roles in medicine still 'carry characteristic images of the kinds of people that should occupy them' (Kanter, 1975;1977:250) and are often organized along gendered lines. Ridgeway and Correll (2004:510) define gender as 'an institutionalized system of social practices for constituting people as two significantly different categories, men and women, and organizing social relations of inequality on the basis of that difference'. Organizational practices in turn, reinforce the segregation of work by gender, widen status and income disparity between men and women, and replicate cultural stereotypes of gender (Acker, 1990). Research shows that widely disseminated gender beliefs and stereotypes are still prevalent in the United States (Lueptow, et al., 2001), although organizations differ in the severity and the extent to which these inequalities exist and are endorsed (Acker, 2006). Gender stereotypes portray women as less competent, and better at less valued communal tasks when compared to men who are viewed as status worthy, instrumental and agentic (Ridgeway and Correll, 2004). Studies (Heilman, et al., 1995) show how in our society the role of a manager has been culturally associated with men. In professional fields that have been culturally perceived as masculine like management, defense, or medicine (Heilman, et al., 1995; Swim and Sanna, 1996), 'the evaluative bias in favor of men is stronger (Ridgeway and Correll, 2004:518).' Therefore, even

when women perform comparably to men, men are regarded as being more capable at a given task than women (Correll, 2004 ; Foschi, 2000) who may have to accomplish more than men to be rated equally (Pugh and Wahrman, 1983). Unlike men, women are also deprived of their due recognition at the workplace and are underrepresented in positions of management and leadership (Eagly and Karau, 2002; Reskin and Ross, 1995).

Gender and racial discrimination act as a double bind for minority women in medicine, who consistently report ‘a more significant impact of discrimination than that for men’ (Carr, et al., 2007:607). However the interlinked impact of gender and race in shaping the career trajectories of Asian-American women has largely remained unexamined (Xu and Leffler, 1992). Especially regarding the conditions of new racially different immigrant groups, the interconnected complexity of gender and racial inequalities requires further analysis. Focusing on either one category ignores the internal divisions of races along gender lines, and precludes an understanding of how the two categories have a complex, mutually reinforcing or contradicting interaction (Acker, 2006).

CHARACTERISTICS OF THE MEDICAL PROFESSION

Besides, medicine as a profession by itself is particularly susceptible to discrimination against minorities because of its inherent characteristics.

First, differentiation in the quality of positions and their financial rewards inhibits foreign medical graduates, women, and minorities from joining competitive specialties. Studies show that there are relatively less Asians than Whites in competitive specialties (Brotherton and Etzel, 2010) and it is not the FMG's but the U.S. graduates who are selected in branches that are more lucrative financially (Ebell, 2008). In fact 44 percent of the foreign medical graduates in the United States provide primary care when contrasted with 33 percent of U.S. graduates, most of who opt for competitive specialties that are also financially remunerative (Kumar and TB, 2007). While competitive procedure-oriented specialties and sub-specialties like general surgery, gastroenterology, neurosurgery, urology and orthopedics emerge as exceedingly discriminatory fields for women and foreign graduate physicians alike.

Second, the relatively unstructured competition in U.S. medicine to secure residencies and desirable specializations that are dispersed across the country, leads to the use of markers to facilitate the sorting of candidates, such as foreign name and their migration status. A qualitative study at the Johns Hopkins University School of Medicine of non-tenured physicians in the tenure track found racial/ethnic bias and disparities in the recruitment of minorities and foreign-born residents, fellows, faculty, and in their rank advancement within academic medicine (Price, et al., 2005), also seconded by earlier studies (Fang, et al., 2000; Palepu, et al., 1998). Research shows that in spite of the U.S. residency slots in specialties like psychiatry remaining unfilled (Frieden, 1996), FMG's are

denied applications in psychiatry and family practice programs (Nasir, 1994) on the basis of their name and 'the school from which he or she graduated, without evaluating individual qualifications and skills' (Balon, et al., 1997:1609). Despite the requisite standardized exams taken by FMG's like the USMLE and TOEFL (Kuncel and Hezlett, 2007), intake of FMG's is discouraged in many programs because of the widespread perception within the U.S. medical community that such programs are inferior (Riley, et al., 1996). Surgery in particular is infamous for discriminating against FMG's (Moore and Rhodenbaugh, 2002) with surgical directors acknowledging 'external pressure not to rank a better qualified IMG (ECFMG) over a USMG (U.S. graduate)' (Desbiens and Vidaillet, 2010:3).

Third, the hierarchical nature of medicine and with it the discretionary power that attending physicians acquire over medical residents, and fellows often emerges as a potent tool to perpetuate discriminatory attitudes in medical settings (Cook, et al., 1996; vanIneveld, et al., 1996). An attending physician in U.S. academic medicine, is a physician who has completed his residency, and practices medicine in a clinic or hospital setting, and oversees both residents and fellows. Resident is the term used to address students in the graduate medical training that is called residency. Residents are supervised by attending physicians who may have an academic title such as 'Associate Professor' or 'Professor,' and also by 'fellows' who are training in a particular sub-specialty after having completed their residency. The significance of medical hierarchy lies in its power that is derived from the individual's judgment of competence and

appropriateness and less on impersonal criteria of merit like examinations or publications. As a result, individual judgments on residents and fellows by attending physicians are more likely to lend themselves to discrimination.

Fourth, the recruitment and retention of foreign medical students, who potentially can become part of the U.S. labor markets, creates an added avenue for the implementation of discriminatory behaviors and practices. There were 109, 840 active residents in ACGME-accredited programs during the 2009-2010 academic year, out of which 27.4% or 30,068 were FMG's (Brotherton and Etzel, 2010). In fact among FMG's, Indians constitute the largest number of overseas trained physicians within the American medical community (Kumar and TB, 2007). Research shows that foreign medical graduates (FMG's) who are largely first-generation immigrants face added prejudice and are discriminated very or somewhat significantly (Coombs and King, 2005), either overtly or in subtle ways on the basis of their country of origin, xenophobia, and chauvinistic attitudes (Desbiens and Vidaillet, 2010). They also often report 'nuanced, isolating and difficult interactions within workplace hierarchies' (Chen, et al., 2010:952). Having an accent and a 'primary language other than English' further consolidates the 'outsider status' of minority faculties in U.S. medicine (Peterson, et al., 2004:263). However with the U.S. still confronting physician shortages in many regions and specialties, the American Medical Association continues to depend heavily on FMG's to help address the healthcare needs of a rapidly aging population (Raymer, 2004).

Finally, unlike other professions medicine is a person-oriented field, where Indian physicians are susceptible to discrimination on a daily basis. This is particularly apparent in the direct interactions that physicians have with their patients, who may adopt general societal stereotypes of the kinds of people who are competent or desirable, and may discriminate against physicians by race, gender, nationality and religion. However, considering the centrality of racism in scarring the lives of physicians of color, what is conspicuous by its complete absence is much contemporary research on the workplace experiences of physicians of Indian origin in the United States. The addition of gender, nationality and religion to race amplifies the power of discrimination, and the interlinked impact these characteristics have in suppressing the occupational mobility of ethnic minorities. More research is required to understand the effect of race and ethnicity on the professional outcomes of human capital workers from ethnic minorities in the United States.

SOCIAL INCORPORATION OF NEW IMMIGRANTS AND THE SECOND-GENERATION

Traditional theories of incorporation assume that greater assimilation follows with more time spent in the United States and is accompanied by comparable increase in the social and economic achievements of immigrants (Kim and Sakamoto, 2010; Zhou, 1997). Consequently, high skilled immigrants who join the U.S. mainstream economy after graduating or completing their

professional training from U.S. schools are believed to experience a smooth on the job transition akin to the native born (Alba and Nee, 1997). Among the high skilled immigrants, Asian Americans constitute the fastest growing minority group in the United States with 48.7% of Asian Indian men, 41.6% of Filipino men, and 35% of Chinese men being college graduates when compared to 23.3% of the total U.S. male population having a college degree (Waters and Eschbach, 1995). Moreover, Asians are two-thirds more likely than whites to have finished college (Harrison and Bennett, 1995). This is partly because of the selective immigration criterion of 1965 that encouraged only a select group of Asian Indians with scarce skills to immigrate and join professional and managerial ranks in the United States (Kurien, 2001). So much so that in lieu of their professional success and high rates of intermarriage in the United States, studies suggest 'their acceptability to many whites', and 'the absence of a deep racial divide' for Asians (Alba and Nee, 1997:846; Lee and Yamanaka, 1990; Qian, 1997).

However research shows that people of color in the United States continue to experience substantial discrimination and prejudice in all aspects (Bonilla-Silva and Glover, 2004; Feagin and Vera, 1995; Kim and Sakamoto, 2010). Structural arrangements following a racial hierarchy provide social and economic advantages to whites by offering them better opportunities in terms of 'enhanced college admissions, favored job interviews, improved career opportunities, and higher labor market rewards' (Kim and Sakamoto, 2010:935;

Saenz and Morales, 2005). Whereas for Asian Americans, despite their professional attainments in the United States, studies suggest that educational returns are lower for them when compared to whites (Hirschman and Wong, 1984; Wong, 1986). And they are required to be more educated to receive a similar income to whites (Waters and Eschbach, 1995). Another study found that despite being highly educated, Asian Americans were paid lesser than whites for comparable or similar ranks (Barringer, et al., 1993). Earning differentials still persisted across ethnic groups even after controlling for other factors like level of education, region, and occupation (Kim and Sakamoto, 2010). With race in the United States playing a salient role in identifying and defining people in relation to others (Blumer, 1958; Bonilla-Silva, 1997; Cornell and Hartmann, 1998; Winant, 2000), immigrants and their offspring's often have to navigate through the racial barriers structuring occupational hierarchies, and availability of resources to them (Itzigsohn, et al., 2005).

Moreover studies acknowledge the dearth of research on the economic incorporation of highly skilled immigrants as compared to undocumented immigrants and immigrant entrepreneurs (Alba and Nee, 1997). Scholars (Alba and Nee, 1997; Portes and Zhou, 1993) argue that the existing data on new immigrant groups pertains more to the arrival and settlement of earlier immigrants in the United States. And it sheds less light on the adaptation process of the new second-generation or the 1.5 generation children whose outlook is radically different from their post-1965 immigrant parents and which alone can

help reach any decisive and important conclusions on assimilation and it's limits for the new immigrant groups (Portes and Zhou, 1993; Rumbaut, 1994; Waters, et al., 2010). Theorists assert that native-born Asian Americans and the 1.5-generation offer the best parameters to measure racial discrimination because 'their pre-labor market characteristics are more readily comparable to whites' (Zeng and Xie, 2004:952).

Besides, Portes and Zhou (1993) argue that unlike the new second-generation, an important factor that differentiated the children of European immigrants was their fairer skin color that greatly facilitated their incorporation into mainstream America. Economic incorporation of the new second-generation has also become problematic today because of the drastic reduction in intermediate opportunities. This has left the new entrants into the U.S. labor markets with either accepting 'the minimally paid menial jobs' that immigrants would usually occupy or strive for 'the high-tech and professional occupations requiring college degrees that native elites occupy' (Portes and Zhou, 1993:76; Sassen, 1985). But very little is known about the economic adaptation and the social incorporation of new immigrants today and the new second-generation in high skilled professions like medicine in the United States.

Even less is known about the subjective experiences of the second-generation that includes 'their modes of ethnic or national self-identification, perceptions of discrimination, aspirations for their adult futures, cultural

preferences, forms of intergenerational cohesion or conflict within their families, self-esteem and psychological well-being' and how these are related to 'their school and work performance' (Rumbaut, 1994:752). The subjective experiences of the children born or raised in the United States are also complicated by the fact that they are not going to be placated by their parent's constant narratives of how dreadful the situation was in their home countries when compared to the United States. Instead, they are liable to assess their own socio-economic adaptation and potential, and be judged for these by others, by the similar standards, which Americans conform to (Zhou and Xiong, 2005).

The racial stratification in the United States intrinsically constricts the national self-identification of new immigrants and their second-generation counterparts. This is reflected in the fact that a large majority of 1.5- and second-generation Asian Americans choose to 'identify themselves as hyphenated American rather than 'American' while perceiving the United States as home' (Zhou and Xiong, 2005:1148). However, Zhou and Xiong (2005) argue that choosing hyphenated national identities to identify themselves is actually a reactive response on the part of the second-generation Asian Americans. It is indicative of their diffidence towards their own ethnic heritage, and also of their awareness and resentment of the discriminatory treatment entailed by the U.S. racial hierarchy. Besides the new second-generation has to battle repeatedly the 'immigrant shadow' that labels the first-generation as 'foreigners' and often threatens to envelope them as well (Kibria, 2002; Zhou and Xiong, 2005).

‘Resembling the new immigrants in phenotype, but not necessarily in behavior, language, and culture, the more ‘assimilated’ U.S-born or U.S. raised Asian Americans find that they must actively and constantly distinguish themselves from the newer arrivals, often derogatively referred to as ‘‘FOB’’ (fresh off boat)’ (Zhou and Xiong, 2005:1149). Tuan (Tuan, 1999) in her research shows how second-generation Asians are seen as “too American,” by their foreign-born counterparts and not conversant enough with their indigenous cultures. Attitudes of first-generation immigrants towards their second-generation counterparts have been documented in other studies as well (Chen, 1992; Lee, 1996; Uba, 1994; Weiss, 1973b). Lamphere argues that newcomers and established residents reside in ‘divided social worlds’ ridden with social distance (Lamphere, 1992). Modern institutions that promote exclusion, and isolation between the two groups further reinforce this social distance. Bach (1993) argues that with the decline of unions, and the collapse of large-scale manufacturing, the work force is fragmented. As a result the labor markets have become sharply separated in the United States with established residents and immigrant groups claiming ownership over specific activities and areas. It is this segregation, which leads to tensions when these groups come into contact (Bach, 1993).

RESEARCH QUESTIONS

The core research questions that guide this project are:

1(a). Why do Indian physicians emigrate in large numbers to the U.S.?

1(b). What do they find as problematic in the organization and the practice of Indian medicine?

1(c). How do they conceptualize the possibility of returning to India versus staying in the U.S.?

2. How does racial discrimination at work and institutionalized racism in particular, shape the career trajectories of Indian physicians in the U.S.?

3. How do Indian women physicians cope with racial and gender-based discrimination at work, and with the resultant role strain that emanates from their efforts to strive for work-home balance?

4. How does racial discrimination outside of the workplace affect the social incorporation of first and second-generation Indians in the United States, and how are they affected by, their own inter-generational conflicts?

5. How does the racialized and gendered organization of U.S. medicine affect the migration outcomes for transnational high-skilled ethnic groups compared with the effects of, intra-group and inter-group race prejudice?

RESEARCH METHODS

Sociologist Herbert Blumer underscored the importance of qualitative 'grounded' inquiry when he noted that the only way to 'get assurance is to go directly to the empirical world-to see through meticulous examination of it whether one's premises or root images of it, one's questions and problems for it, the data one chooses out of it, the concepts through which one sees and analyzes it and the interpretation one applies to it are actually borne out' (Blumer, 1969:32). Qualitative methods are used for the questions this research pursues

as they are perfectly suited to understand the meaning of participants' lives in their own terms (Janesick, 1994). For this reason, my research project uses semi-structured interviews, where 'two individuals come together to try to create meaning about a particular topic' (Esterberg, 2002:85). I used a snowball sampling technique using contacts provided by Indian physicians employed or in training at a major medical centre in the U.S. Southwest.

The proposed research site for this project constitutes one of the largest metropolitan areas in the United States housing one of the major biomedical research centers, making it one of the major destinations for Indian physicians in U.S. Southwest. I established my initial round of participants by randomly contacting them through their emails available on their department websites of the medical center that was my field of study. Once I established my initial round of participants, I requested them to refer me to other physicians who might be interested in participating in this study. In my email I indicated that I was interested in how Indian physicians experience race relations at the work place, and racial and gender discrimination, if any, in particular. And what role does this play in shaping the return/non-return of first-generation Indian physicians to India. First, this framing would enable me to keep the nature of the data gathered broad-based in terms of my participants' experiences, while allowing me to explore the types of discrimination experienced. Second, and more importantly it would give the prospective participants a broader overview of the conversation we would have, rather than my catching them off guard, considering the sensitivity of the subject and reluctance of many physicians to share their candid

opinions on the issue. I sensed their disinclination after I began snowballing and a number of first-generation physicians stated that they did not want to participate in the study or did not respond to my emails. This occurred despite their having been discriminated at the workplace, as I found out through the physicians who gave me their reference.

I identified 108 physicians -43 women and 65 men in the summer and fall of 2009 and 2010 (Table 1). 13 of these physicians were re-interviewed in 2010. These re-interviews were foundational in revealing new insights from the respondents who had acquired more comfort and trust in our conversations since the first interview. This study also includes phone interviews with Indian physicians in the United States who were residing outside the geographical scope of the research. Of the total sample size, 50 interviews were carried out with first-generation Indian physicians, 51 interviews were carried out with second-generation Indian physicians, and 7 interviews with senior faculty in higher administrative positions. I use pseudonyms for my study-participants in order to protect the confidentiality and the privacy of my respondents.

The criteria of eligibility for the participants include self-identifying as physicians of Indian origin, being over the age of eighteen, and engaged in training (residency or fellowship) or employed at the time of the interview. To be categorized as second-generation, participating physicians had to have been born in the United States and have one or two immigrant parents. Immigrants,

who migrated to the United States when they were ten years old or younger and underwent most of their childhood and adolescent socialization in the United States, are characterized by Rumbaut and Portes (2001) as the 1.5 generation. Although not second-generation, the physicians who belonged to the 1.5-generation category identified themselves as second-generation in my interviews as they did not foresee any commonalities with first-generation Indians.

My sample consists of a wide range of first and second-generation Indian physicians from varied specialties of medicine and surgery, including residents, fellows, faculty and physicians employed in private, academic and government practice. I stressed 'depth, detail, vividness and nuance' (Miller and Crabtree, 2003:188) in my interviews. I requested each of the research participants to talk about their workplace experiences in the United States, what motivated the first-generation Indians to immigrate to the United States and their perspective on return to India; and how discrimination by race, gender, and inter-generational conflicts if any, shaped their social spaces at work and outside of work. I also inquired about their interactions with supervisors, colleagues, and patients, and the reactions of administrative authorities to incidents of racial and gender discrimination at work. The open-ended interviews through which the female and male respondents shared their experiences and their career trajectories ranged from half an hour to two hours, and an hour on average. I found similarities, as well as differences, between the experiences of first and second-generation physicians of Indian origin in this study. In this dissertation, I will outline each of

the findings and explain how racial and gender discrimination, along with inter-generational conflicts between first and second-generation Indians defines the social incorporation of Indian physicians in the United States and results in the dilemma of return that is experienced by first-generation Indians.

My sample of one hundred and eight informants does not represent the totality of physicians of Indian origin residing and practicing in the United States. I am not offering a concrete, linear analyses of racial and gender based discrimination experienced by them at the work place and outside of work. Instead I try to provide a micro view, a participant observer's sense of how race, and gender intersect with migration and affect their social incorporation, rather than a macro prophetic one (Marcus, 1998). Moreover, given the sensitive nature of my interviews, I am aware of the extent to which the study participants were self-selected, forming a "convenience sample" to give greater exposure of the social conditions in question (Duncan, 2008). Nevertheless I greatly benefited from this process, since the self-selection process helped me to interview only women and men who were forthcoming and candid about revealing how they truly experienced race and gender relations at work and outside of work to me. I have attempted to portray their experiences in this research with the same sincerity and honesty.

CHAPTER BREAKDOWN

The major purpose of the chapters that follow is to examine the character, range and depth of the discrimination physicians of Indian origin encounter in the

United States, its impact, and the ways in which they cope and respond. In the following chapters I quote from my interviews with an emphasis on those with the most detail and insights about the experiences of these physicians. This dissertation is divided into five chapters based on the diverse yet interrelated subjects explored in my conversations.

Chapter 2 examines the underlying causes behind the migration of first-generation physicians from India to the United States. It looks at the changes that migration brings in their social and economic pattern of life, along with the role of networks and remittances influencing their migration trajectories. I also explore their perspectives on the medical brain drain from India, the central problems with the organization and practice of Indian medicine that leads to such large-scale emigration of Indian physicians to the US, and medical tourism as a potential route to return back to India.

Chapter 3 investigates the incidence of racial discrimination against physicians of Indian origin in the United States. It looks at the foreign medical graduate bias in American medicine, racial bias in positions of power, social distancing between first and second-generation Indian physicians, and finally the differences and similarities in the experiences of first and second-generation Indian physicians along the above lines.

Chapter 4 looks at how gender based discrimination in American medicine shapes the professional and personal trajectories of women physicians of Indian origin. This includes discrimination of these physicians by their patients, and the role strain experienced by them in their quest to achieve work-home balance, and to conform to Indian and American values.

Chapter 5 focuses on two aspects that reflect the external and internal struggles of Indian physicians and impact their social incorporation into the American mainstream: (1) racial discrimination in public places, and (2) discriminatory family attitudes at home and their own internal conflicts generated by these.

Chapter 6 reviews the initial goals of the dissertation project in light of the research findings. It also looks at the research problems that occurred in course of this research, along with a discussion of the main findings within the larger debates on professional migration and discrimination of high skilled ethnic groups in the United States. It concludes by considering the prospects of future research on the subject.

Table 1: Characteristics of Physicians of Indian Origin Enrolled in the Study

Variable	First-Generation (N = 50)	1.5 Generation[1] (N = 21)	Second-Generation (N = 30)
Age Group, n (%)			
18-30 years	9 (18)	6 (29)	10 (33)
31-40 years	21 (42)	11 (52)	18 (60)
>40 years	20 (40)	4 (19)	2 (7)
Males, n %	33 (66)	10 (48)	19 (63)
Marital status, n (%)			
Single	2 (4)	5 (24)	7 (23)
Married	46 (92)	14 (67)	23 (77)
Divorced	1 (2)	2 (10)	0 (0)
Widowed	1 (2)	0 (0)	0 (0)
Duration of stay in the US, n (%)			
<5 years	3 (6)	--	--
5 – 10 years	13 (26)	--	--
11 – 20 years	28 (56)	--	--
>20 years	6 (12)	--	--

[4] The economy of India is based in part on planning through its five-year plans, which began in 1951, and were developed, executed and monitored by the Planning Commission, with the Prime Minister as the ex officio Chairman.

Table 1, continued.

Caste, n (%)			
General	40 (80)	18 (86)	18 (60)
Reserved	6 (12)	1 (5)	0 (0)
Not reported	4 (8)	2 (10)	12 (40)
Visa status at the time of immigration, n (%)			
B-1	3 (6)	--	--
F-1	10 (20)	--	--
J-1	12 (24)	--	--
H-1B	13 (26)	--	--
H-4, J-2	8 (16)	--	--
Permanent Resident	4 (8)	--	--
Specialty, n (%)			
Dermatology	--	1 (5)	--
Family medicine	1 (2)	--	--
Internal medicine	19 (38)	6 (29)	14 (47)
Neurology	3 (6)	--	1 (3)
Pathology	4 (8)	1 (5)	1 (3)
Pediatrics	8 (16)	7 (33)	7 (23)

Table 1, continued.

Physical medicine and rehabilitation	--	2 (10)	--
Psychiatry	10 (20)	2 (10)	4 (13)
Radiology	1 (2)	--	--
Surgical specialties	4 (8)	2 (10)	4 (13)
Professional Status, n (%)			
In-Training[2]	15 (30)	6 (29)	10 (33)
Faculty[3]	33 (66)	15 (71)	19 (63)
Private-Practice	2 (4)	--	1 (3)

[1] These are immigrants who immigrated at a young age and underwent most of their childhood and adolescent socialization in the United States.

[2] These are residents and fellows in-training at a University hospital setting.

[3] These are practicing physicians at a University hospital setting.

Chapter 2

MIGRATION OF INDIAN PHYSICIANS TO THE UNITED STATES

EXPLORING THE "BRAIN DRAIN"

"Chen and Boufford (2005) call the migration of physicians from poor countries to rich countries "fatal flows"… The chairman of the British Medical Association has described encouraging health professional emigration from poor to rich countries as "the rape of the poorest countries." Mills et al. (2008) take the extraordinary step of recommending that international recruiters of health professionals from developing countries should be tried for "crimes against humanity" (Clemens, 2009:8).**"**

What initially began as a short-lived movement of 'transient professionals' stimulated by the increasing international demand for specialized services (Harris, 1995) in the twentieth century has indeed come a long way into emerging as a 'fatal flow' for developing countries like India. It was in the second half of the twentieth century that a large majority of Indian physicians immigrated to the United Kingdom, United States (US), Australia, and Canada for their graduate training and medical practice (Mullan, 2006). Almost 60,000 graduates from medical colleges in India are now practicing in these countries constituting '10.1 percent of the 592,215 physicians registered by the Medical Council of India' (Mullan, 2006:381). Moreover, there are around '5,000 graduates of Indian

medical schools in U.S. training programs today, meaning that approximately 1,200 enter into the U.S. residency system each year' (Mullan, 2006:386).

This large-scale emigration of Indian physicians is accompanied by the rapid growth of a physician workforce that is less likely to be engaged in gainful employment in urban India in the coming decades. The distribution of practicing physicians in India is heavily skewed toward urban areas that are already saturated with a large number of physicians. In effect the Center for Enquiry into Health and Allied Themes estimates 'the urban physician-to-population ratio at almost six times the rural concentration of physicians' (Mullan, 2006:383). As a result, students with the highest academic achievement have the greatest likelihood of migrating (Kaushik, et al., 2008:43). The better quality of these physicians fuels their desire for 'better training and increased access to enhanced technology and equipment' constituting important reasons for migration (Kaushik, et al., 2008). Within the last two decades, there has been an exponential increase in the number of medical graduates in India. With medicine being a widely respected profession in India that is often associated with job security, running a medical college has become a lucrative business resulting in the rapid proliferation of medical colleges in India. While there were only 163 medical colleges in 1997, this number grew to 335 by the year 2012 (MCI). Along with this, the number of medical students increased dramatically from 11,800 admissions per year in 1990 to 24,000 in 2005 (Jeffery, 1976; Mullan, 2006) and to 40,525 by the year 2012 (MCI). New private medical colleges account for most

of this growth, with many of these being owned by local politicians and influential businessmen who reap financial and political rewards through the authority they exercise over these colleges.

While the Medical Council of India (MCI) is required to assess the available infrastructure and resources prior to accrediting these colleges, the accreditation standards if at all are very modest and focus on documentation of infrastructure rather than the quality of education (MCI, 2012c). In fact the chairman of MCI himself has been recently prosecuted for collecting substantial amounts of money for giving recognition to these colleges without proper scrutiny. This rampant corruption is not at all surprising or new. In fact the Guru Gobind Singh Medical College which was opened in Faridabad (Haryana) was the subject of a political scandal in 1972 because of its virtually non-existent facilities, and yet was 'bailed out by the central government's intervention and reopened in Punjab' (Jeffery, 1976:503). This is also evident in the tuition that private for-profit medical colleges charge for admission of medical students, irrespective of the criterion laid out by the MCI (Mullan, 2006). This growth in the number of medical colleges and students is not matched by a parallel growth in the resources and number of faculty. Nationwide, there is a 20-25% shortage of faculty in most departments (Ananthakrishnan, 2007) which is primarily attributed to the unwillingness of qualified physicians to take up faculty appointments on the existing salary and support structure.

The precarious situation of the supply of physicians surpassing their demand in urban centers could be classified as a cumulative effect of a number of factors at work. To begin with, the supply of physicians was one of the few goals of the Five-Year Plans in India[4] which was not only attained but was even exceeded on many occasions (Jeffery, 1976). Jeffery (1976) argues that a substantial emphasis was laid on the production of physicians till the 1970s in anticipation of the bottleneck that the scarcity of health professionals could create in delivering national health plans. Nonetheless, it was the early 1960s, which actually emerged as the decade that witnessed massive production of physicians in India. It was when 'the defense services found it difficult to recruit doctors' during the 1962 Indo-China war, that 'the Medical Council of India agreed to permit medical colleges to exceed the number of students that they had adequate facilities for' (Jeffery, 1976:503). As a result, the age distribution of physicians skewed greatly towards those under 45, with 'only about 850 to 1,000' physicians leaving the labor market annually as opposed to the yearly addition of 10,500 physicians (Jeffery, 1976:504).

So while there is generous production of physicians in India, their emigration is exacerbated by the problematic inter-regional mobility of physicians in India. Physicians are often reluctant to settle and work in rural areas because of the dilapidated medical infrastructure and the extensive variation in the amenities, medical expertise, and trained staff that is available in the rural areas.

[4] The economy of India is based in part on planning through its five-year plans, which began in 1951, and were developed, executed and monitored by the Planning Commission, with the Prime Minister as the ex officio Chairman.

To make matters worse, private practice in rural settings is not financially remunerative, as physicians have to compete against quacks or local resource personnel who are cost effective and more familiar to their clients. These are usually local villagers who treat patients pretending to have the medical skill and qualifications that they actually do not possess. In addition to the lack of resources, migration to urban areas is further exacerbated by the problematic inter-regional mobility. For example, physicians in India often have an inclination to reside in the cities in which they were born or educated due to the language barriers between states that make recruitment of local personnel more practical. This was reflected in the 1971 Special Census that found 90 percent of physicians residing in their state of birth (Jeffery, 1976). This is also evident in the density of the health workforce (per 10,000 population) across Indian states, ranging from 23.17 in Chandigarh to 2.51 in Meghalaya (Datta, 2009). As a result, the majority of the physicians are 'concentrated in urban areas, which include only about 20 percent of the total population of India but about 75-80 percent of the doctors' (Jeffery, 1976:504). Not surprisingly, the urban private hospitals that serve the rapidly growing upper and middle socioeconomic class, are unable to provide adequate financial compensation for doctors practicing in those areas. Thus many of these doctors look for opportunities outside of India and migrate to the U.S.

The high cost of medical education in private medical colleges (approximately $75,000–$100,000) and low financial reimbursement rate in India

is another important factor in the emigration of Indian physicians to the U.S. where the potential income is much higher (median salary for an Assistant Professor in India is <$15,000 per year versus upwards of $100,000 per year in the U.S) (AIIMS, 2011; Healthcaresalaryonline, 2012; Mullan, 2006). Physician emigration is also accentuated by the prestige that postgraduate medical trainees from the U.S. enjoy in India and the flexibility that physicians now have by having the option to take the United States Medical Licensing Examination in India unlike in the past when the exam was held in Singapore or Bangkok.

Although medical emigration from India has assisted in compensating for the scarcity of physicians in countries like the United States, India is presently at a crossroads in terms of its own healthcare workforce. Under-staffing of physicians accompanied by the loss of health professionals is reported to have an adverse impact on national healthcare in the short term, while depriving the nation of its academic investments in the long term (Shaffi, et al., 2007). The expected shortage of health workers in India is estimated to be around 20% (in accordance with the WHO standard of 25 per/10,000) which could be around 0.4-0.6 million (Datta, 2009). India requires 600,000 physicians, 100,000 nurses, 200,000 dental surgeons and large numbers of paramedical staff (Sinha and Singh, 2008). ‘For every 10,000 Indians, there is one doctor. In contrast, Australia has 249 doctors for every 10,000 people, Canada has 209, UK has 166 and US has 548,’ as reported by the Planning Commission (Sinha and Singh, 2008). With the majority of physicians practicing in cities in India, there are only

50–60 physicians per 100,000 population (Mullan, 2006). Efforts by the government to remedy this dichotomous distribution have not been successful (Jeffery, 1976). Besides, India's public expenditure on health remains less than one percent of the gross domestic product (TheEconomist, 2001).

RESEARCH QUESTION

In this chapter, I use my interview data to explore the reasons that Indian physicians have for leaving India. Finally, I will look at the change that migration brings in their social and economic pattern of life that influence their migration outcomes and further solidifies their reasons to stay in the United States. The sections which follow address findings of the three major issues that emerged in my interviews.

FINDINGS

Why Do First-generation Indian Physicians Migrate from India to the United States?

One of the central factors in leading the physicians that I interviewed to leave India for the United States is the superiority of U.S. education, which is seen as providing a more structured and supervised atmosphere. And their perceptions fit with the available research data.

For example, Mihir, who resigned from a surgical residency at the All India Institute of Medical Sciences (AIIMS) in New Delhi, and immigrated to the U.S. in 2003, was very dissatisfied with the training offered at AIIMS. AIIMS is reported to be India's top ranked medical college, admitting students through an objective exam, in which 45 students from a typical pool of 30,000 applicants (0.15%) are selected (Kaushik et al., 2008). Mihir explained, "When I joined the residency program, I thought that it's the best program in the country…so when I got admitted, I thought that this would be the best training available. But after I joined I was very disappointed with the kind of training that was being offered at AIIMS. And as I mentioned it is considered the best program in the country. So I was really disillusioned, and I thought that if this is the best available training then this is not worth the amount of effort I am putting in this training." Similarly, Saurabh who emigrated for better academic opportunities explained how "the trend there [in India] is to do xerox and development rather than research and development, sort of rehash what has been done before".

Others migrated either because they could not get a residency position or in search of better opportunities to pursue an academic and research career, financial security, good lifestyle, freedom to pursue their goals with less bureaucracy and political interference, and lastly the potential to get U.S. citizenship. One such example is Atif who left because he felt that the opportunities to pursue subspecialty training in Pediatrics were very limited in India. On the other hand, Shiv was able to get a faculty position at a premier

national medical institute in India. However, he left because even after being a faculty for 4-years, he could not get a permanent position, and instead had to get an extension every 6-months from the health ministry in New Delhi.

Reservation of seats by lowering the entry criteria for under-represented castes in medical colleges in India also emerged as a significant factor that compelled many physicians to emigrate. Mohit explained how the pumping up of reserved seats from 22.5% to 50% in institutions of higher learning that were funded by the central and state government, when he was a medical student in India drove many people to the United States. Kanika, Vivian, Ridhima, Shantanu, and Goel, all mentioned how reservation of seats in medical colleges in India affected their decision to emigrate directly or indirectly. In fact Nimit felt that reservations dealt "the final blow" to his decision to emigrate. Like Kanika he felt that "this place [Indian medical colleges] doesn't deserve us…I would hate to work with a person of the same status who doesn't know a thing but he is still working with you because he was promoted just because of his caste which is kind of ridiculous. Even in medical college majority of them [students from reserved castes] who came, they performed poorly, they were not interested much in studies, exceptions are always there…all they would do is booze, party and fail multiple times and ultimately pass the medical school in like rather than five years, they will pass in ten years. And then they get a government job and they get promoted multiple times." Intense competition for the few available post-

graduate training positions and limited job opportunities in cities worsened the already precarious situation.

In contrast to Mohit and Nimit, Ayaan also experienced casteism but in an opposite manner. Ayaan, who has trained at some of the Ivy League medical schools in the U.S., attributed his decision to emigrate to the racist medical environment at AIIMS, unlike in the U.S. “Because I did my medical school from All India Institute of Medical Sciences (AIIMS), and there to do your residency in Internal Medicine you have to have seventy percent or more marks in your medical school. I didn’t have that, so I could not do residency at AIIMS…I am a premium example. I was a failure at AIIMS. And I tell you, I have done the best among my class. And in India I faced racism, not here, because of the caste. I was from Bihar, from a lower socio-economic status, they did not let me pass, they wanted to kick me out of AIIMS, and it’s ridiculous.”

I also found that women still constitute a small minority of Indian physicians who migrate independently unlike men. In my sample of 108 physicians with 43 women, only four women participants Gitanjali, Savita, Piyali, and Parvati emigrated independently to the US. All four of these women migrated for better training and career opportunities while the rest of the women physicians immigrated either after getting married to their spouses who were already residing in the U.S., or along with their husbands.

The Trials and Tribulations of Indian Medicine: Personal Accounts

Further, I found that the disorganized and unethical medical practice in India played a big role in promoting migration and preventing return of these Indian physicians. Charak, Saurabh, Saagar, Sana, Mangal, Padamja, Shantanu, Dinkar, Madhav, and Nagesh, all testified against the "patchy", "chaotic" and "unethical system of practicing medicine" in India that prompted physicians to maximize their income often by inappropriately hospitalizing their patients, and compromising patient's interests. Dravid concurred how medicine could get quite dirty in India: "There is a lot of cut back; there is a very bad referral pattern. You have to give cuts (bribes) too, and especially if you are a specialist you have to give cuts to people referring patients to you…you really have to woo the primary care physicians to send you patients…there is a lot of incentive for people to do some unnecessary tests…So it will be hard for me to adapt to that system where you have to network…". Gitanjali felt that there was not much oversight to medical care in India along with the bottom line desire to make more money, which led physicians to do certain things that would be "questionable". Likewise Charan stressed that the unorganized work practices, lack of opportunities, and absence of government support in India were a major deterrent against return of physicians. He explained: "…If you compare AIIMS to some of the best medical colleges in the U.S., it might be comparable, but if you compare the peripheral medical colleges the conditions are very bad…and why they [Indian Physicians] don't go back is because once they are here, there are more opportunities here. Like I just have done a fellowship here in spine surgery, and sitting in India we

used to think that we have to do residency and all that stuff. But after coming here…in the U.S. people need lot of doctors, if they feel that this person can serve the country. I was at [Ivy League medical university]; they will think that this person can serve me, so they will try to keep me, and they will provide opportunities to me, which does not happen in India. You still have to make your own opportunities".

Moreover, when it came to joining academic medicine in India, Raju, and Saagar felt that finding faculty jobs in India was "virtually impossible" unless one had the right connections. Saaras explained how "it's not about what you do, it's about who you know and what you do. But who you know actually comes before what you do or what you know". In fact out of his class of 200 medical students, more than 130 are in the U.S., United Kingdom and Europe. At the same time, Raghav, Madhav, and Mangal were skeptical about the lack of new technology, devices, electronic medical records, any structured support from departments, and "opportunity to develop a full fledged research career". Dinkar who emigrated from AIIMS for academic reasons argued how the research environment in India was not structured to do "good basic and clinical research", how lab-based research was difficult, particularly with the dearth of good mentors.

In a similar vein Ayaan elaborated on the incongruous nature of medical training in India. "It is ridiculous. There are few colleges, which are really good…I would say 95% of the medical schools are sub-optimum. And part of the reason

being that when you practice medicine there's something called the art of medicine, 'Oh this doctor feels that I have this disease and therefore I must be treated that way.' But in the US what they have done is that they have codified each disease manifestation, and there's an evidence-based practice in medicine. So if you have disease A with symptom B, then we know by research that treatment Y works. Therefore treatment Y will be given by 90% of physicians. In India…No. Each physician has his own interpretation of medicine, which is wrong and this is the problem." Nimit explained how "in India professors would be just stuck on age old methods of history taking and physical examination... even in postgraduate examination and training nobody talked about these new advances, nobody talked about researches, nobody talked about like what's new and what's current and how do you need to manage the patient. It was all focused on how you would come to the diagnosis, because that was the most important thing in India given the limited resources, tests...that you could order." His fear that with such training he would not be up to the mark in the next 10-15 years and would still be struggling at that point in time, led him to emigrate. What was increasingly shocking was the lack of adequate level of supervision in training in the best medical colleges of the country coupled with a condescending attitude towards students. Mihir contended:

"At AIIMS what I felt was there is no appropriate level of supervision. And there was no appropriate level of independence either. When I talk about supervision, I was being supervised by the '*babaji*', who is basically the orderly in

the outpatient clinic and minor operation room, and probably the charge nurse who was in-charge of the minor operation room and outpatient clinic. There was no senior resident or attending to supervise me either in my outpatient clinic or in the minor operation room. And that was in the beginning of my residency training itself…and there were incidents when I needed help because I didn't know what I am doing, and I did page the senior resident couple of times, and they were nowhere to be seen. So I basically took help from another resident who had joined just like me and the two of us together figured out what to do, and how to make the bleeding stop, and we packed it up and sent the patient home knowing what we did is wrong, knowing that the patient will get infected and will come back next week, hoping that when he comes back next week, we will have a senior resident who can help us figure out what to do. Not only that, there were faculty members who would comment, 'why do you need to learn so much at this time or if you learn everything right now what will you learn in future. That was the kind of encouragement I got…so if that was the kind of training I was supposed to get there, then there was no point in spending that amount of time. When I say that amount of time, it was 110-120 hours a week that I was spending. And when I talk about supervision in clinical settings, I have killed patients while working in surgery at AIIMS. And I killed them because I didn't know what I was doing, there was no one to tell me what I was doing…and we killed not one but probably more than one patient, and I can vividly remember whom I killed and I still feel guilty about it…"

Moreover, like Gitanjali, Mihir argued that there was absolutely no infrastructure in India to give training to residents and fellows. And the government hospitals like AIIMS were overburdened with the number of patients, leading to an emphasis on number of patients seen rather than resident training. This was unlike the U.S., where research was much more pervasive and most hospitals affiliated with medical schools engaged in good quality research. A fact confirmed by Mihir who elaborated his dismal experience of research with a faculty at AIIMS: “It was a shady project which was probably proven or disproved in early 1980s in the U.S., so we were just trying to prove or reprove it in Indian setting...so obviously I knew that this was a stolen project, my boss did not give me any guidance on what to do or what not to do…”. What is more, Ayaan highlighted the inherent discrepancies in the way medical education was organized in India. “Here I think inherently Americans are honest people. Indians are not. Here we rely on the letters of recommendation, that you get a good letter of recommendation, your life is made. In India you can’t do that. Because anybody will write you a flowery letter of recommendation, there is no tradition of relying on letter of recommendation. Here we do. And that is a very thin ice. And if it were not based upon faith and trust, that system would not work. And in India it would not work. So, the current system in India of marks is the only objective evidence. You cannot rely on letters of recommendation. You know somebody may come with five people writing letters of recommendation for them”.

Likewise Savita also questioned the competency of medical students who came through the quota system in India: “If you see the quality of the people who are coming in, it’s very much below par. And I understand that we have to do something but the gap between the deserving candidate and the reservation candidate should not be that big. And it was pretty glaring at times…you feel like you are being deprived of your right, you are deserving and you are not getting what you really deserve then I can think it makes you very frustrated. And that maybe another reason for exodus from there”.

Mapping Socio-Economic Trajectories along the Life Course: What Change Does Migration Bring in the Social and Economic Patterns of Life of Indian Physicians?

All of the physicians interviewed for this study reported varying experiences with regard to the social and economic changes that occurred in their day to day lives after migrating to the U.S. There is no uniform pattern of assimilation since region, class, religion and family of origin all strive to influence their perceptions of the United States. Saurabh, and Nimit did not experience any considerable difference in their social lives post-migration, while Mohit reported to have a better circle of friends in the U.S. For Sana and Kanika, friends became family after migration, with a lot more inter-dependence and helping out. Interestingly, Shiv whose wife is from northeast India and a Christian had a very limited circle of friends in India who were liberal in their thought process like them. But on moving to the U.S. he felt that his social circle was “much better” as everyone was open-minded like them. Vivian on the other hand felt that it was more of a

“downgrade” socially for him after migration, as he missed the social status, prestige and family name that he had in India. He explained, “It’s not that we are treated any different, it’s that we are not treated any better”.

For Vicky and Gitanjali being in the United States, had been a period of growth for them just by living in a different culture. In fact being in the U.S. gave Gitanjali an opportunity to interact beyond her community. She explained, “When I was growing up, almost all my friends were from Karnataka…I have had more friends from all over India since I have been here. So I think that is a major change. I didn’t have opportunity to meet and mix with people from other states, whereas here I have friends from Gujarat, Rajasthan, Bengal, Punjab, so that’s different. And I like that; I enjoy mixing with other people, knowing their cultures.” For Piyali emigration to the United States resulted in increased freedom to date men and choose her own life-partner. During her medical school in India she felt that there was an expectation that if she dated someone she would eventually have to marry that person, so she never dated anyone. Moreover, women could not drink alcohol in her family and if they did they were not respected as much. Now being in the U.S. she does enjoy drinking occasionally.

Migration to the U.S. also resulted in the loss of family and friends for many physicians. For Charan, social life in the U.S. as compared to India was significantly different as were the cultures of both the countries. He explained, “...when I came here initially it was difficult to adapt to this culture. There is more

of social life in India definitely. Here there is social life but it is different I will say. I won't say there is no social life. The difference is like, anytime you cannot just go to anyone's house, going to a party is like very much pre-planned and time bound, it is not at someone's house and there are no social meetings as in India. And I did not have many friends here with whom I can go and play in the evenings, or I can go to movies". Likewise Avtar too felt: "I have a lot of family in India, a lot of friends, at least I had friends then… socially I do not have any friends or family here…at least close friends…. Now it has been 10 years since I have come. I enjoyed a better social life there". While Savita felt that: "You really don't miss India. Everything is available here, but the essence is not there, the actual soul is not here…"

Similarly, Shantanu, Mangal, Dinkar, Goel, Suhana and Kirpal experienced tremendous difference in their social lives on migration with no family support, difficulty in making friends and developing their own social circle in the United States. Suneeti explained: "In India all the neighbors are friends; all the persons you come across become friends. Whereas in U.S. it takes a lot to develop friendship…like you have acquaintances, you don't develop friendship. Also so many times you have to look for the people of Indian origin to become friends, and if you are living in an area where there are not many Indians, then it's hard to find friends. Like we still know our neighbors here, it's not that we don't, but that's not the friendship that you develop in India that you will walk into their home or they will cook something and they will invite you right away to

‘come in’”. Likewise, Aarti agreed, “…here we are kind of isolated. So there has been a difference in the social pattern of our life. But I guess there are penalties to pay if you choose to live away from India…”

Although most physicians interviewed for this study felt that it would be inappropriate to compare their earnings in India when they were medical students to now in the U.S. when they are residents or faculty with full-time jobs, quite a few felt that they could have done economically as well in India as in the U.S. However to truly capture the economic impact of migration we need to take account of the economic trajectory of the immigrants. The financial effect of migration on our study participants varied greatly in response to their economic situation and standing of their families back home. Physicians, who hailed from upper class families in India, witnessed no remarkable change or in fact a deterioration in their economic lifestyle after having immigrated to the United States. Charan, Alok, Rajesh, and Komal reported no change in their economic situation post-migration, still working the same hours, and getting a residents salary. Likewise, for Suneeti and Aarti immigration to the U.S. had not been economically enriching. Avtar instead felt that he was in fact worse off economically in the U.S.: “In India it was better. I was living with my parents, had a very good socio-economic status. So I enjoyed and shared the same socio-economic status with them. In my own salary I would have had a much poorer socio-economic status, because in internship I just made like 3,000 rupees a month. But since I was living with my parents I enjoyed a much better socio-

economic status than here…. We had servants there, we still have servants, driver, gardener, and all those benefits are there which are not here. Even if I were to go back today, I would enjoy a better socio-economic status than here…economically also it's not like I am doing any better than my parents. I have the same style and status of living. I had better status of living in India than I have here. I had a car there, I have a car here, I had a house there, and I have a house here. I had in fact a bigger house there, than I have here. So economically and socially I am doing worse here than there, but educationally and professionally I think I am doing better"

Contrary to this, the migratory experience of physicians from middle and lower middle class backgrounds led to a significant spurt in their opportunities, income, and autonomy, instigating upward social mobility. Mihir, Ajay and Dravid felt that economically they are better off now, as compared to when they were in India. Mihir explained, "I make money in dollars which is more than rupees, and I definitely can spend more than what I could, I can have more gadgets, I can travel more which I like, I can buy more gifts for my family which I like, and which I could not have done even being a resident in India". Likewise, Saurabh, Ridhima, Raghav, Mangal, Padamja, Kirpal, Manu, Nagesh, Viraat, Kanika, Jiya and Gitanjali experienced much more financial freedom and earning potential in the United States. For Gitanjali, her economic transformation after having immigrated to the U.S. was drastic, and had subsequent impact on her social life as well. She explained, "Well economically we come from a lower middle class

background in India, and I am one of nine children, so we weren't rich by any means, but we were comfortable, all my siblings were educated, but that was it. We didn't have any luxury. Whereas I came here and right from the beginning during my internship year, I had more money than I had ever seen. Because as interns, the stipend that we get is pretty generous. I trained in Chicago, and I had free room and boarding, meals were free, so I really had no expenses except for my clothes and personal items. So the end of the first year I bought a car, so I could move out of there, and commute from a distance, so that was a big difference. And since I have been working, I guess I would be called upper class here now, economic status wise…and in terms of cultural activities, we used to attend plays while in Bangalore…but again now I do have the time, and I certainly can afford, and the opportunities are there too to attend cultural activities, symphonies, plays, dances, both Indian and western, and I enjoy that".

DISCUSSION AND CONCLUSION

Medical migration or "brain drain" has been the subject of several investigations led by many organizations including the Institute of Medicine and the Council of Graduate Medical Education in the United States (Lohr, et al., 1996). Overall 1/3rd of Indian physicians emigrate to practice in other countries. Developed nations such as the United States, the United Kingdom, Canada, and Australia benefit the most from this mass migration and 11% (59,523 out of 563,423) of the graduates of medical schools in India practice in one of these four developed nations (Mullan, 2005;2006). Among the developed countries,

United States is the most preferred destination for Indian physicians (N = 40,838; 4.9% of the total physician workforce in the U.S.), more than the other three developed countries combined (N = 18,685) (Mullan, 2005). Indian medical schools supply the largest number of foreign medical graduates to the United States. (Kumar and TB, 2007). This is an ongoing phenomenon since Indian physicians constitute the largest proportion of foreign medical graduates applying for residency positions in the United States and 16% (N = 1,590) of all ECFMG certificates issued in the year 2011 were issued to graduates of Indian medical schools (ECFMG). Despite the rigorous and often discriminatory process of selection, the expense of taking United States Medical Licensing Examination, and ongoing perceptions about the inferior quality of training and performance of foreign medical graduates (Rojas, et al., 2011); the number of Indian physicians that apply for residency positions in the United States is increasing (ECFMG).

Poor infrastructure and lack of opportunities in India, both in terms of clinical practice and research, is at the core of migration of Indian physicians to the U.S. Compared to the U.S where healthcare spending accounts for over 17% of the gross domestic product (GDP) (CMS), healthcare expenditure accounts for less than 2% of the GDP in India. Not surprisingly, none of the Indian medical institutions are included in the list of world's best universities. Contrast this with the Indian Institute of Technology in Mumbai, India that was ranked 50th among the world's best universities for computer science in the year 2011 (USNews). Consistent with these observations, many of my interviewees expressed

dissatisfaction and doubts regarding the quality of medical training and research in India. As most of the respondents commented, medical education in good government schools in India is extremely subsidized, to the extent that they did not really pay anything. This has made medical training of physicians a drain at the public expense, with India spending almost $5 billion since 1951 in the overall training of physicians (Narasimhan, et al., 2004; Shaffi, et al., 2007).

Although not limited to private schools, most of my interviewees reported that commercialization of medical education in India also had an adverse impact on the quality of training. Just like Gitanjali, others (Muraleedharan and Nandraj, 2003) reported that “oversupply of doctors in the private health sector has also created unhealthy competition that has led to unnecessary or excessive medication of otherwise healthy people.” Since Indian medical colleges are the largest exporters of physicians to the rest of the world, the quality of training of these physicians has significant implications not only for India but also for the rest of the world. Therefore in addition to taking steps to encourage “reverse brain drain”, there is a need for standardized assessment and accreditation of medical colleges in India.

Third, the limited availability of postgraduate training (residency) positions and the implementation of quota system during selection of residents and faculty emerged as another important reason propelling immigration of physicians from India. The Indian society with its various regional and cultural differences is still

struggling to cope with the socioeconomic and caste based inequalities. While selection in medical colleges is almost exclusively based on marks scored in an entrance examination, a lower cutoff is used for students belonging to “Scheduled Castes (SC)”, “Scheduled Tribes (ST)”, and “Other Backward Classes (OBC)”. The allocation of seats in publicly funded training programs is based on performance in the postgraduate entrance exams, which are offered once every year by individual states. The students are tested on multiple-choice questions and are accepted to their preferred specialty based on their rank in the exam. The institutions funded by central government have a separate but similar examination system while private medical colleges have a proportion of merit seats as well as payment seats. There are about 200 colleges that offer various degree programs for postgraduate medical training in India (MCI). Over 75,000 students compete each year for the 11,392 available residency positions implying that only 1 in 6 students will get an opportunity for postgraduate training (ElsevierExamZone). The competition is stiffer for clinical specialties. Not only is the number of training positions very limited, the Indian education follows a quota system such that 50% of the available seats are reserved for SC/ST/OBC. Scheduled Castes (SC), Scheduled Tribes (ST) and Other Backward Classes (OBC) are the three groups of historically disadvantaged people that are the main beneficiaries of the reservation policies under the Constitution of India. As a result of this quota, very often the candidates belonging to one of the reserved categories get selected despite getting very low scores in the entrance exam while those belonging to the general category may not get admitted despite

performing significantly better on the entrance exam. For example, at one of the premier institutions, the cutoff for admission into M.B.B.S. course for general category was 68% compared to 42% for the SC/ST candidates (results of entrance exams are displayed publicly in India). This differential admission process biases the examination process towards people belonging to one of the reserved castes, most of who are wealthy hailing from affluent families that have already availed of reservation in government jobs and have had equal or greater access to education and career opportunities. As recently as 2006, there were nationwide protests against the way the quota system is currently implemented. This quota system does not end with training positions. Rather a similar system applies all the way from junior faculty to higher administrative positions. Several of my interviewees expressed their frustration with this system, which puts caste before merit. They also expressed doubts about the skills and ability of physicians who join medical school through the quota system. In fact Kaushik (2008) shows that students who were admitted to AIIMS through the affirmative-action program had a greater likelihood of staying back in India and not emigrating than those who did not qualify for this benefit.

Besides, faculty development or the lack thereof is a critical issue in the migration of physicians who were able to navigate the Indian residency training system but encountered a bottleneck at the faculty level. Due to financial constraints and possibly due to different priorities, career development of junior faculty gets neglected even at the premier medical institutions in India. For

example, the faculty recruitment process at AIIMS has remained controversial for the last two decades. Since 1993, AIIMS recruited 126 faculty members on an ad-hoc basis who were required to get their contract extended on a yearly basis. While 110 of these positions were finally converted to permanent posts in 2003, only four years of their clinical experience were accounted for resulting in loss of valuable professional experience for physicians who were working on an ad-hoc basis for over 10 years (Chatterjee).

Healthcare in India

The healthcare infrastructure in India is extremely dilapidated, under staffed, poorly equipped and inept to meet the current health needs of the country (PricewaterhouseCoopers, 2007). Due to the shortage of physicians and adequate infrastructure at AIIMS, patients miss out on medical care and quality time in diagnosis. “An outpatient at the institute on average gets four to nine minutes of attention from a doctor, while the waiting time for surgery ranges from 2 to 34 months. And at least three patients terminally ill with cancer are turned away each day for lack of healthcare facilities. The outpatient department, originally designed to cater for 500 patients a day, now receives nearly 6,000 each day” (Kumar and TB, 2007; Mudur, 2001:28). ‘India needs 74,150 community health centers per million population but has less than half that number. In addition, at least 11 Indian states do not have laboratories for testing drugs, and more than half of existing laboratories are not properly equipped or staffed’ (PricewaterhouseCoopers, 2007:5).

Moreover, most of the health care funds are spent on the private sector. Healthcare in India is essentially divided into three sectors: the run down public sector catering to the urban mass, the state of the art private sector catering essentially to the rich including medical tourists in urban cities, and the rural sector where majority of the Indian population lives but has inadequate or no access to quality care. 'In 2003, fee-charging private companies accounted for 82% of India's $30.5 billion expenditure on healthcare…Private firms are now thought to provide about 60% of all outpatient care in India and as much as 40% of all in-patient care. It is estimated that nearly 70% of all hospitals and 40% of hospital beds in the country are in the private sector' (PricewaterhouseCoopers, 2007). Private sector is not only the predominant provider of healthcare, it is perceived to be of a "higher standard" (Nagral, 2011). However, with the health insurance sector being relatively underdeveloped, only 11% of Indians have access to health insurance schemes (PricewaterhouseCoopers, 2007) and the vast majority of health expenses are borne by the patient.

Besides, two-thirds of all Indian hospitals and health care centers are located in urban areas, only 25% of the total Indian population has access to western style of medicine, with the rural poor having to depend on Ayurveda, Acupuncture, Unani and other alternative medical treatments (PricewaterhouseCoopers, 2007). Vanessa, a senior faculty in an administrative position argued, "There's a lot of need for health care there [India]. You know you

see these kids on the street that have unrepaired cleft lip, and all kinds of deformities. There are all kinds of communicable disease that's treated. There need to be physicians working in public health and sanitation. To me there's such a huge need. Aren't there more people there than here? You know if we are underserved here, they got to be underserved." This is partly because of the reluctance of physicians in India to practice in rural areas. Prakash argued that if something was not attractive then one needed to dole it up to make it attractive. Physicians did not want to practice in rural areas, as the government did not make it appealing for physicians particularly because of the meager pay scales offered in already dysfunctional health establishments. He questioned, "Why are not ministers living in rural India? They are not. Why are not politicians going to rural India and living there?" Exacerbating this bleak scenario are the cut back's in national health programs, the decline of the public sector from being the leading employer of physicians it once was, and the failure of governmental schemes to encourage self-employment of physicians due to the stringent requirements accompanying providing credit (Jeffery, 1976).

Finally, the experiences of women physicians in India and their reasons for migration to the U.S. were similar to their male counterparts. In addition, women reported a strong gender bias in India against women such that women physicians are largely concentrated in specialties that are less time and labor intensive. For example, at AIIMS, 'after excluding obstetrics and gynecology (66%) and ophthalmology (32%) from the surgical branches, only 5% are

women, whereas anesthesia has 39%. There are no women faculty in the administration, examination and research sections, forensic medicine, hospital administration, orthopedics, neurosurgery, nephrology, gastrointestinal surgery, gastroenterology, oncology, oncosurgery and nuclear medicine' (Sood and Chadda, 2008). In contrast, a significant proportion of the women I interviewed were successful in securing senior administrative as well as highly competitive positions upon migration to the U.S.

The Social and Economic Impact of Migration

Although prior studies have addressed the economic impact of migration of Indian doctors on the Indian and the U.S. economy, little information is available on the social assimilation and economic trajectory of these doctors after migration to the U.S. Through my research, I was able to explore and gather information on Indian doctor's subjective feeling of economic growth and integration into the American society. The findings from my interviews highlight that personal characteristics, baseline socio-economic status and family structure have a dominant influence in shaping the trajectory of migrant Indian doctors. Due to their special skill set and ability to communicate in English, Indian doctors quickly improve their economic position after migration to the U.S. and become comfortable with the western lifestyle. However, Indian doctors, particularly those belonging to higher socio-economic status in India, often do not experience any significant improvement in their monetary status. For example, both Avtar and Suneeti felt that their socio-economic status either remained unchanged or

worsened after migration to the U.S.

While economic prosperity continues to attract many Indian doctors to the U.S., it appears to become less of an issue a few years after their immigration when social isolation acquires predominance. Despite the fact that several of my respondents had been residing and working in the U.S. for over a decade and had children that were enrolled in school, majority of them felt that their social life had been better in India. This is in contrast to other migrant communities where level of education, language proficiency, and duration of residence serve as important determinants of social assimilation (Dustmann, 1996). The intensity of isolation varied between different respondents but in general was influenced by their personal characteristics, how they navigated the caste system in India, family and social environment, their ties to India, as well as the receptiveness of the American community at their place of work and home. Although not investigated during my interviews, others have suggested that stronger interpersonal contacts with other migrant Indians when compared to the non-Indians and residential segregation may be other obstacles to social assimilation of Indian doctors in the U.S. (Shah, 1991; White, et al., 2003).

In my study, a majority of the first-generation Indian doctors immigrated when they were between 20 and 30 years of age, had completed medical school, and were fluent at communicating in English. Therefore it is unlikely that their social integration was constrained by age, education, or language related

barriers. I did not observe any trend towards greater assimilation of recent migrants versus those who migrated several decades earlier. Most of my respondents compared the social structure in the United States with that in India. Majority of these physicians viewed the U.S. social structure unfavorably, which most likely made it harder for them to get accustomed to U.S. norms and expectations. This resulted in a vicious cycle where unfavorable impressions and social isolation sustained each other.

Unlike their U.S. educated engineering counterparts who have played a transformative role in contributing to Indian economic development by their entrepreneurship and by building professional and business ties in India, the U.S. trained Indian physicians seem to contribute little beyond family remittances. With the United States constituting the most favored destination for health professionals from India (Khadria, 2004), Dinkar argued that India is loosing its best researchers at the level of cutting edge research, “once in a while you have an Indian noble laureate who would not have won the noble prize if he had stayed back in India.” Although physicians like Saurabh do engage in research collaborations in India, physicians like him are a rarity. Dinkar stressed that it was important that the Indian government not only made the physicians stay back but also attracted brains from different parts of the world, inciting a reverse brain drain.

This study shows that expectations and experiences of physicians are not

immutable, but are influenced by their stage in the life course, their access to material and institutional resources in the home and the host country, and largely by their own conceptions of their growth and ‘well being’. It is imperative that the Indian government takes concrete measures to step up the healthcare and sanitation situation in rural India while providing structural and financial support to physicians abroad intending to return back to the country if it intends to redeem its national health sector.

Chapter 3

RACIST MEDICINE

EXPERIENCES OF INDIAN PHYSICIANS WITH RACISM AND INTERGENERATIONAL TENSIONS IN AMERICAN MEDICINE

" I remember one incident where a surgeon from Southeast Texas asked [my father, also a surgeon, in the hospital premises] why the tiger population in India was diminishing? If perhaps because of over-population encroaching upon their environment, rather than alluding to those reasons, he said, 'why don't you just feed skinny Indians to the tigers so that their populations can grow?' he asked my father. And my father retorted, 'you know those skinny Indians they don't have much skin; they don't have much muscle on their bones. I think the tigers would do better eating fat, southeast white surgeons,' in retaliation.**"**[5]

Rahul Seth, In-depth interview, (US), August 2010

Racism in medicine has been described as a cradle to grave experience for Asian physicians (Everington, 2004; Garg, 2007) and remains a heavily researched area in the United Kingdom (Coker, 2001; Dyer, 1997; Esmail, et al., 2003; Esmail and Everington, 1993; Esmail, et al., 1998; Garg, 2007) unlike in the United States. Coker argues, from the moment that physicians from minority groups apply to medical school till they retire from practice, they encounter either

[5] Names of all the respondents have been changed to protect their identity.

the threat or the reality of racism (Coker, 2001). They undergo racial discrimination in recruitment (Anwar and Ali, 1987; Cooke, et al., 2003; Esmail and Everington, 1993), disciplinary procedures (Allen, 2000), reward systems (Esmail, et al., 2003), and the visa regulation changes by the government that circumscribes their training and restricts career promotions and employment chances (Fox, 2006; Garg, 2007; Unwin, 2001). Many Asian physicians find that their careers have been blighted by institutional racism, contemptuous bias, lack of sensitivity for diversity and respect for equality that nurtures the racist medical environment in the U.K. (Deccan Herald, 2008; Llandudno, 2004; Tribune, 2008).

I contextualize this research within the Indian medical community in the United States, which functions within the intersections of migration and race. While most race research focuses on the social incorporation of the first-generation, there are a growing number of studies that focus on the new second-generation (Alba and Waters, 2010; Kasinitz, et al., 2008; Picca and Feagin, 2007; Portes, 1996; Portes and Rumbaut, 2001; Zhou, 1997), which represents the 'most consequential and lasting legacy of the new immigration' (Lee, 2005:296). As compared to first-generation Indian physicians, what makes the second-generation group unique is the fact that they are growing up in United States, one of the most diverse countries in the world, are untarnished by the FMG (Foreign Medical Graduate) stigma, and unfettered by visa regulations governing their entry/exit and overall career trajectories. Therefore, I include in my analysis a comparative exploration of racist experiences endured at work by

first vis-à-vis second-generation Indian physicians, and attempt to map comparative similarities, as well as differentials, marking their respective workplace trajectories in the United States.

RACE AND THE DIFFERENT BASES OF DISCRIMINATION

With 'the color line' transforming itself in historically new ways, problems of race and racism in the present times have propelled back the concern 'for the phenomenon that Du Bois characterized as the problem of the 20th century' (Harrison, 1998:609). Benedict, one of the earliest scholars to employ the concept of racism defines it as 'the dogma that one ethnic group is condemned by nature to congenital inferiority and another group is destined to congenital superiority' (Benedict, 1945:87). Alternate perspectives on racism by Marxists and other conflict theorists (Cox, 1948; Perlo, 1975; Szymanski, 1981;1983), condense racism 'to a legitimating ideology used by the bourgeoisie to divide the working class' (Bonilla-Silva, 1997:466). While the institutionalist paradigm (Carmichael, 1971; Wellman, 1977) distinguishes racial discrimination as basically an institutional process of exclusion of out-group's by the dominant race on 'ascribed and particularistic grounds of group membership rather than on achieved and universalistic grounds of merit' (Pettigrew, 1975:10). Likewise, the internal colonialism standpoint (Barrera, 1979; Moore, 1970), views racism as institutional and founded on a system that upholds the social position of the White majority 'by exploiting, controlling, and keeping down others who are categorized in racial or ethnic terms' (Blauner, 1972:22).

Bonilla-Silva (1997) argues that serious theorization and reconceptualization of 'racism' is marred by the assumption that racism is self evident and is a purely ideological phenomenon. These conceptualizations treat racism as a psychological and static phenomenon to be understood at the individual level, notwithstanding how racism becomes entwined or institutionalized in organizations and social practices (Bonilla-Silva, 1997). Feagin and Sikes study of racism among middle-class blacks finds that racism is actually induced by racial prejudice that is backed by power and resources on an institutional level (Feagin and Sikes, 1994). Here racial discrimination is often embedded in organizations and is tied to certain formal or informal rules that embody the specific race interests of the dominant groups, such as white Americans (Feagin and Eckberg, 1980). Racism is further bolstered by bureaucracies that discriminate against subordinated nonwhites to serve the interests of more powerful actors, as shown by Sjoberg, Brymer, and Faris (1966). It is imperative that modern racism be understood as lived experience, more so since blatant discrimination of the past has been joined by much subtle and covert discrimination (Feagin, 1991; Feagin and Sikes, 1994).

Academic medicine in particular mirrors this new face of modern racism in the United States as against the overt racial discrimination of the past that personified the 'old racism' (McClain, 1986). Moreover, medicine as a profession by itself is particularly susceptible to discrimination against minorities because of

its inherent characteristics. Recent studies on American medicine find that racism smothers the dreams and livelihoods of many medical students, as they discover that their 'ability to handle medical school no longer is enough to merit the opportunity for a medical education' (Shervington, 2000:1). 'Financial constraints, insufficient exposure to medicine as a career, little encouragement at home and in schools, lack of role models, and negative peer pressure' have emerged as some of the chief factors contributing to racial disparities in the physician workforce for African Americans (Rao and Flores, 2007:986). These findings are corroborated by studies in the northeastern United States investigating black residents' perceptions of the impact of race on medical training, which find perceptions of overt discrimination to be rare. Instead, the study participants who were black residents, perceived black trainees to be punished more severely for similar offenses and 'expected to perform at lower levels than white counterparts' (Liebschutz, et al., 2006:1441). In addition, social isolation enforced on them by their white colleagues contrasted against the connections they experienced with other black physicians, patients and support staff whom the study participants found to be greater sources of support (Liebschutz, et al., 2006). Fourth-year medical students and members of the American Medical Student Association belonging to underrepresented minorities reported that 'their race caused them to feel that they had to be twice as good to be treated as an equal to other students' (Bright, et al., 1998:681). They also reported the absence of a mentor as well as a same-race mentor as a big hurdle (Bright, et al., 1998). Likewise, under-represented minority faculty are less likely to be promoted to associate or full

professor (Petersdorf, et al., 1989) and identify 'difficulty of cross-cultural relationships; isolation and feeling invisible', lack of 'social capital; disrespect, overt and covert bias/ discrimination' as barriers (Pololi, et al., 2010:1363). Although Asian-origin groups are often stereotyped as 'model minorities,' research shows that they have to overcome significant barriers in the labor market (Espiritu, 1997; Fong, 1998a; Purkayastha, 2005b; Stone, et al., 2006). Thus the addition of each one of these socially categorized indicators to race amplifies the power of discrimination, and the interlinked impact they have in suppressing the occupational mobility of ethnic minorities.

CHARACTERISTICS OF THE MEDICAL CAREER

As noted in chapter 1, differentiation in the quality of positions and their financial rewards inhibits foreign medical graduates, women, and minorities from joining competitive specialties. There are relatively less Asians than Whites in competitive specialties (Table 2). It is not the FMG's but the U.S. graduates who are selected in branches that are more lucrative financially (Table 3 and Figure 1). Competitive procedure-oriented specialties and sub-specialties like general surgery, gastroenterology, neurosurgery, urology and orthopedics emerge as exceedingly discriminatory fields for women and foreign graduate physicians alike. Considering the labor and time involved in these areas, these are also the higher paying specialties in American medicine in which male American graduates instead are encouraged at the workplace. While women physicians and foreign graduates are steered more towards thinking of less time and labor-

intensive specialties like psychiatry, pediatrics, and family medicine that are non-competitive and less remunerative fields at the same time.

The second possible source of discrimination that I identified in the literature is the relatively unstructured competition to secure residencies and specializations that are dispersed across the country. Relationships between first-generation immigrants and their second-generation counterparts are a third area of discrimination that I will explore through the interviews. However, as my research will show, even when high status immigrant groups and their second-generation counterparts work together in similar fields at the same platform, mutual stereotyping and distrust often leads to workplace tensions between the two groups.

The fourth factor identified in the literature review as resulting in discrimination is the hierarchical nature of medicine and with it the discretionary power that attending physicians acquire over medical residents, and fellows often emerges as a potent tool to perpetuate discriminatory attitudes in medical settings. Fifth, the recruitment and retention of foreign medical students, who potentially can become part of the U.S. labor markets, creates an added avenue for the implementation of discriminatory behaviors and practices.

In this chapter, I explore how Indian physicians experience these different bases of discrimination. In the following pages, I argue that workspaces of Indian

physicians in the United States are significant social spaces for the perpetuation of racialized norms in the workplace. Additionally, I use my interviews and observations to delineate the context of social distancing at the workplace, which has created a paradoxical split due to discrimination of foreign-born Indian physicians by dominant groups and by their own ethnic counterparts who identify as second-generations in the interviews. I found similarities, as well as differences, between the experiences of first and second-generation Indian physicians in this study. Moreover, familial inter-generational tensions experienced at home by second-generation Indian physicians played a key role in determining their interactions with first-generation Indian physicians at the workplace. In the remainder of this chapter, I will outline each of these consequences and explain how racial discrimination at work defines the migratory experience of Indian physicians in the United States. Lastly, I will explain how a sociological study of these physicians can help us understand the operation of race, and migration at the medical workplace in new and important ways.

RACIAL DISCRIMINATION IN AMERICAN MEDICINE

A majority of the Indian physicians who were interviewed for this research experienced racial and gender based discrimination at all levels at the medical workplace- as residents, faculty, and in promotions to positions of power. This also includes incidents of overt discrimination by their patients. Several examples

of these reports are given in this section to illustrate and elaborate on these cases.

This study found that racial discrimination in medicine against second-generation Indian physicians begins even before their entry into U.S. medical schools. Manav, a senior second-generation faculty shared, “you can think of discrimination in terms of just selection to medical schools, residency programs. I think there may be some subtle levels of discrimination just because there are so many good applicants of South Asian descent, that medical schools want to have a balanced class of students and the same is true for residency programs, fellowships…” Likewise Tripathi felt that when he and his friends were trying to get into medical school, “felt like there was a little bit of a bias there, cause we didn’t really feel like we were competing for all hundred seats at a particular university, felt like we were fighting for like 10% of the seats based on our being racially profiled…the percentage of Indian kids there [the Caribbean medical school I went to] was ridiculously high. I mean we are talking 75% of the kids there are usually American born of Indian origin. It goes to show you some of the bias they are feeling even within the United States…we are all fighting for those same 10 seats in each school.”

Even once they begin their residency training, second-generation Sadia found that despite White American male residents being in minority in their programs, they are always selected as chief residents every year excluding

women and other races. Sudeep, a senior faculty in dermatology resonated Sadia's sentiments when he acknowledged, "I am trying to think who is our chief resident this last year is a white male, the coming year is gonna be a white male, and previous years was white male, ya that may be the case." Second-generation Harvinder, Omi and Manav felt that racism in the United States today is "much more subtle." Their parents like many other first-generation Indian parents who were cognizant of U.S. racism instilled very early in their children that they had to be "the best of the best" and "better than the best than Americans at work." Omi a faculty agreed that if one is not a "white male," "people do expect us to work hard. They don't necessarily expect everyone to work hard." Similarly Anu felt that people at the workplace assumed that being an Indian "you are gonna be the hard working one, the one who is willing to give in more time and everything without being asked kind of stuff [than others]." Aarti who is a resident felt likewise, "there is always an expectation that you have to work hard and you have to prove yourself to others [at the workplace]…in order for you to fit in, in order for you to have as an Indian kind of find your place, that place comes from working harder than others, doing better and excelling." In fact when second-generation Harvinder who went to a U.S. medical school applied for a Cardiology fellowship at an Ivy League medical University, he never got a response back. And was later told by the assistant who did not even open his application seeing his foreign sounding name that they did not accept any foreign medical graduates.

First-generation Indian FMG's often have a double hit when it comes to discrimination at the workplace. Vanessa, a senior administrative faculty acknowledges, "if you come in with cultural differences or with accent differences then yes you do [have to work harder at the workplace]. I think people are not going to give you the benefit of doubt in that context…there is a lot of prejudice against people who trained elsewhere [in South Asia and Africa]…anytime somebody hears an accent you are immediately I think going to be treated differently. I think you are treated with less respect…people expect you not to be very good and they are surprised if you are…most people by nature are pretty xenophobic, unfortunately." Kanav, a resident recalled, "we have to present cases when we get a patient. So when they are doing that, if it is somebody other than a white blonde [woman] he [attending] would go on yelling and yelling, 'it is inappropriate, completely inappropriate.'…And if it is a white blonde than he would just not say anything even if that person does not answer his question or does not properly present, he would not be angry at all or he would be talking about stuff other than medicine, it is very obvious." Likewise Manu's classmate who complained against racism at the workplace felt that he was "not having the same kind of opportunities others were having, he was being singled out, kind of attacked in terms of just simple things, like during rounds and stuff he was pointed out."

Mukul recollected several experiences when he shared how, "one of the attending doctors had pointed out to me a diagnosis when I was just three

months into training saying that I should have known this…it was a very complex diagnosis…the same mistake was committed in front of him by another White person [going to graduate from the residency] after having been three years into the practice, and at that time that person [the same attending] did not say a word…and the other thing was some of the physicians had pointed out to the accent….one of my senior colleagues had spoken that 'we are not taught to do things this way' or something like that…that was kind of a racist comment as if you are pointing to my upbringing…out of the 13 people that I am talking about, 3 or 4 [colleagues were racists at the workplace]…if your boss is like that, then everybody is going to be like that." Govind who filed and won a racial discrimination lawsuit against an Ivy League U.S. medical school explained, "discrimination happens in subtle ways in most of the cases…Firstly, there are comments that they make about Indians in general and doctors in particular, all derogatory comments…even if they don't know anything about the Indian health system…My case is a different case because my program director lied on documents…If I had not fought for it, then it would have gone unnoticed…Even though I was never put on probation, on record it would have gone that I was on probation…this happens all the time." Govind argued that a "stupid boss" like his would perceive a bright candidate as a threat and try to cut them off, whereas a smart boss tries to get the maximum out of a bright candidate and get credit for the work done by them. Omi, a faculty member responded that, "why would you [complain to the administration if discriminated]? If you were trying to move forward, why would you go and talk to the administration that would just be

counterproductive. You try to work within the system or you leave, go somewhere else, and that's why some people have left [in his program]."

Vanessa felt that between the first and second-generation Indians, racism "differs dramatically between the two groups. I think when people sound American there maybe an initial surprise but I don't think people have any problem with it…people that sound foreign other people perceive that as being foreign, as being sort of other." Likewise Maggie who is a program director felt that foreign graduates "will suffer more discrimination and feel more pressures and prejudice." In fact almost all of the study participants agreed that experiences of racial discrimination differed considerably between the two groups due to the "accent" and "language barrier" faced by first-generation Indians. While Raju felt that second-generation Indians were much more "savvy" and "vociferous" in their demeanor with a high "sense of self respect," Atif felt that first-generation Indians lacked the "knowledge of cultural norms and…when to guard yourself and when to act normal…better knowledge of how to negotiate situations, political and social." Goel shared that in cases of lapses at work, first-generation Indians "would be reprimanded quicker than say an American." Likewise Kajol argued that, "it's harder if you are a first-generation foreign medical graduate, to hold positions of power in a hospital." Raghav, a senior faculty in administration felt similarly when he conceded that, "what I have accomplished in the last ten years, if I were say an American White, I would have been at a higher level…if you look at the number of Indians who are right now in academics, not many of them are

in a position of vice-chair or chair." Kirpal too felt that, "a local person [American citizen] who speaks the language and acts like the way local people do I think have more chances of advancement [in university position outside your field] than somebody who is from another country." Raju however attributed this discrimination to the "bad politics" within the Ivy League medical schools and "with the lack of engagement of foreign medical graduates in that level of politics…at any institution the higher you get the more you have to be politically astute. Whereas the natives have got their networks, for most part Indians are not yet in that networking, so I think that indirectly the race may have affected it [leadership positions]."

What was nevertheless interesting was how a number of second-generation[6] Indian physicians felt that race continues to play a significant role in American medicine and in regulating their rank advancements. Second-generation Vaishali, Inder, Nakul, Shekhar, Smriti, and Sadia, and many others felt that the prevailing belief in medicine was that white men were seen as "competent persuaders", and "competent communicators" who gave "prestige" and "legitimacy" to an institution and positions of power. And "any person of any other race will be chosen only if no white person is available to take the position." Vaishali confessed to be still at the "hurdle stage" of counteracting the initial stereotype that "doctor is the guy in the white coat, with the stethoscope and

[6] To be categorized as second-generation, participating physicians had to have been born in the United States and have one or two immigrant parents, or must have migrated to the United States when they were ten years old or younger. This criterion is consistent with the definition of Rumbaut and Portes (2001) of the 1.5 generation, which refers to immigrants who immigrated at a young age and underwent most of their childhood and adolescent socialization in the United States.

usually the stereotype is a white male." Likewise Reema felt that, "when people think of a chief or a chairman especially in surgery they think of a white haired guy and I think anyone who is not that you have to be a little more accomplished to get to that level." Sadia, a resident confessed that when she went on her residency interviews, "most of the people who are in positions of power are still white men."

Deepika felt that there is also a widespread resentment against the achievements of Indian physicians in medicine vis-à-vis other Americans. She shared how there is a prevalent "stereotype of the Indian people, everybody is a doctor anyway. So it's not a big deal that you are a doctor…and American people don't get those spots…it's said in a way that kind of first of all minimizes your accomplishments. And it's almost like they are trying to make you feel bad that you became a doctor." Harvinder admitted that he thought, "that the one thing that I can't change is the color of my skin and I do think that there is in certain parts of the country where there will be an invisible ceiling as to how far I could rise in academics, but its hard to prove that it is because of my color. I mean they can say it's because I am not as good as my other counterpart who is vying for a higher position…but I do think that for academic physicians who are of Indian origin or from India directly, there seems to be a potential ceiling as to how high you can go." Deepika like Khushi and Dravid argued that, "as far as minorities go, there are more South Asian physicians than there are African American, Latino, or other minority group physicians. But I definitely know personally white and

African American physicians in position as you go higher and higher up the ladder, and as you get higher up the ladder, its mostly just white male physicians…I think it's a toss up between white females and black males [the second in the preferred racial rank order after white males in positions of power]." Likewise Manav felt that "it's just more difficult to once again get the acceptance of your peers to let them put you in charge." Omi concurred when he stated that his, "personal feeling is that it's a lot easier to get promoted and further along in any field if you are not a foreigner, compared to if your are a Caucasian, especially if you are a male…I still think that even now in many fields that if you are a foreigner, that you have to work harder to get promoted, or to get noticed or to move on…. No one will admit to that, but that is probably true… There are obviously exceptions to that, people have done well, but I think you have to work hard."

Moreover Deepika felt that as one got older, "its not so much what people say, it's the way they treat you, compared to the people around you." In fact second-generation Puneet argued that "definitely better looking people get promotions easier and move ahead in the workplace easier…whatever is considered the superior race you know fair skinned, light skinned, people probably get promoted…they can be a little less competent at what they are doing but still get promoted, whereas if the darker skinned individual was at the same level they wouldn't get promoted…the fair skinned individuals tend to promote themselves so that they still get promoted whereas the darker skinned

people might not promote themselves as much…as far as the discrepancy between the races…a fairer complexioned person can still be less attractive than a darker complexioned person. But I think it takes those extremes in order to make the darker skinned person better looking…Whereas if you compare just averages, I think the fairer skinned complexion person is almost always going to win better looking." Maggie, a Caucasian woman in senior administrative position agreed that, "there's still an overall disadvantage. But I think it [role of race in promotions and positions of power] is a reason that is considered and I think that anybody that says it isn't is lying. I think people are conscious of it. And some people sublimate it at a sub-conscious level but I think it makes a difference…when I espouse these views to people above me [of making the program more democratic in terms of diverse representation]…sometimes they say I am a 'little nutty'…'are you going to give up on your mission?'"

Generations apart, racism continues to regulate the career trajectories of Indian physicians even within private practice. Abhijeet felt that in the 1970's it was difficult for his parents to get referrals from other established physicians who were in the community. Vaishali recollected how it took the group a few years to put her fathers name "in front of the office whereas another white physician came and his name was up there in six months." Likewise Puneet shared how a second-generation friend of his who had been working in an all white group, felt that he would not be promoted to a partner and it was his race which was a factor "keeping them back", "because he is not white." However, seven first-generation

Indian male respondents that could be classified as 'outliers' in this study brought up a different perspective when asked about racial discrimination in U.S. medicine. Kush and Prakash felt that Indian society based on the hierarchical caste system is by far more racist than American society and workplace culture. While the other five respondents had worked in and actually left the U.K. to immigrate to the United States for medical training and work, since they found British medicine to be far more discriminatory towards physicians of color than medicine in the United States.

Discrimination by Patients

Both the generations of Indian physicians in my interviews collectively felt discriminated overtly or indirectly by their patients at some point of their career. Second-generation Harvinder recollected, "I have had comments like, 'boy, your English is very good, when did you come to this country?' I view that as little more than ignorant. So when they ask, 'where are you from', and I say [a U.S. city], 'no, where are you really from?' [Laughs], I knew what they were getting at the beginning. So there is lack of acceptance, that I am just like their kids, was born and raised here. But because I do look different, the natural reaction is, I am not American." Likewise second-generation Aarti explained how her patients refer to her as "the brown doctor, or you know 'I want my white doctor,'…kind of where are you from, why did you come here type of outlook." Suneeti had similar experiences as she recalled, "…yes I do see several patients who would make the comment, 'I don't understand your English', before I have even opened my

mouth…also the same patients are known as difficult patients in my opinion…people who are going to make a disrespectful comment are going to find something or the other…that you will just have to let it pass…usually I block them…because that may interfere with the proper care giving."

Moreover Indian physicians believe that they are widely discriminated by their patients for religious reasons. Shashi felt that "A lot of times they [patients] will come in and they will be like 'do you believe in god? No, seriously do you believe in Jesus Christ?' In my case I do, but at the same time I don't think Jesus Christ is the only way. So being Hindu allows me to be a little bit more liberal, and they are not open to that at all. I don't try to get into those discussions if possible unless they bring it up and I have to say something." Reema's patient once remarked about her to a staff member that "she is very nice but she is not Christian." Ironically Harvinder who is a Christian and whose ancestors have followed Christianity is often asked by his patients "when did you get converted, so that's a little bit irritating." Vanessa felt that "a lot of people that are strongly self identified as Christians don't feel that someone from another faith can support them, or even that's an affront to them that their physician would not have the same beliefs."

In cases of overt racial discrimination by their patients, Kirpal like other Indian physicians felt that patients "don't want to open to you, they just want to go through the visit very fast." While second-generation Aryaan who was seeing an

older Caucasian patient found that he would not address his questions but talk to a Caucasian resident with him. Nimit like other physicians also commented how his patients would sometimes remark that they did not want to see “any colored doctor.” While second-generation Puneet had a similar experience to Devika when he recollected how a patient came into the clinic, “saw me, saw the color of my skin, and asked me where was I from, and I said India. And he basically said, ‘I don’t want a fucking Indian doctor.’” Ram, a surgery resident argued that, “some patients are overtly racist…I have had some patients call me…a faguette and I think he probably said nigger…he even threw stuff at me…he crumpled up a piece of paper that I wanted him to sign and he threw it at my face…I have had patients at the VA every now and then that are very hostile…that may have referred to my ethnicity or skin color.” Vivian and Surya also recalled racial slurs like “nigger”, “sand nigger”, and “raggheads” that their patients had used to address them. In fact patients requests not to have a colored doctor were seconded by medical administration and staff as Reeta reminisced a case when “the administration even up in the ICU…was asking well who is here that’s non-Asian, non-Indian that could take care of this patient. It was almost as if they were trying to cater to them and to pacify them in some form and instead of fighting just say that if there is somebody else that can step up great, and if there is not then you just go ahead and do your job and if the family has a problem with it, then they will have to deal with it later which I thought was very interesting too.”

Moreover Vanessa shared that “patients are very suspicious of somebody who has a foreign sounding last name…ever since the second war in Iraq, and the 9/11, that [racism] is a big problem…patients are angry…I think there is a lot of anger around that.” After the 9/11 attacks Deepika like Arpita is often asked by her patients “where are you from”, which country, “are you Muslim” or “are you Arab.” Smriti explained that, “in the past, Indians were probably more glossed over…this [racial attacks] happened with the Japanese during World War II…That’s pretty standard remark that you should go back to your own country, you shouldn’t be here, you don’t know anything…we don’t ever mention it [to the administration], I mean unless they come out and wanna take a gun and wanna kill you or something, we don’t really bring it up to them. We expect that some of this is going to happen.” Likewise Inder often finds that “when a patient is upset they will say things like ‘go back to your own country, I don’t talk to people from your part of the world…I don’t talk to foreigners.’” Besides Indian physicians like Mohit and Goel are often referred to as a “Pakistani” or an “Iranian” by patients. Even second-generation Sadia who practices Islam was discriminated and blatantly asked to leave the room by her patient because of her religion.

BIAS AGAINST FMG’S IN AMERICAN MEDICINE

Cutting across the generation divide, all the first and second-generation physicians in my interviews, although with differing causal explanations, unanimously attested to the pervasiveness of an “overt bias” against FMG’s, and “across the board preference” for American graduates in the United States, and

in determining their access to residency spots, fellowships and faculty jobs. Vivian recalled that “almost every other foreigner in my program [shared experiences of having felt racially discriminated]…some of them almost talk as if they have been taken to Guantanamo Bay.” Atif recollecting his experiences in residency shared, “the general undercurrent that all people had was…they used to favor people of their own ethnicity [in a residency class of 50% FMG’s and 50% USMG’s]…there were subtle ways that they would do it…favoritism or support…and it was in day to day things that you could feel that…these two chief residents in our program, there was never [a foreign medical graduate who became the chief resident] for the three, or four or five years, they had a tendency to sort of pick people from who were American graduates [and not on the basis of merit].” While Mukul felt discrimination during his residency training took the shape of “giving more weekend calls to someone…while making schedule…making some kind of tacky comments like, ‘have they not taught you?’ He also felt that “in residency you have to be on your toes [learning a new system and], because if you commit some mistake or if you prove to be too lazy, then probably I feel that you can get away if you are American. But if you are not American then with the same level of laziness, you might be the target or you might be removed from the residency.” Likewise Pamela admitted that, “ [if] there is some problematic issue, and the medical staff chief would call in the Indian physicians and ask for an explanation versus that some local guy can get away with it. Exact same thing, but these guys will be reprimanded for their actions.”

Similarly Vineet alluded that mistakes of FMG's "were bigger mistakes than if those same mistakes were made by their colleagues."

Elaborating on the FMG bias in American medicine Shyam explained, "[if you didn't go to US medical school] you are automatically seen as the next level down. "There is a general feeling that a hospital that hires lot of foreign graduates is not as good as one that gets all American people," Jayant argued. Deepika and Devika too felt that the FMG label carried with it a "negative connotation," and "it's just assumed that if you are a foreign medical grad you are not as smart; you are not as good, which is completely wrong." And this FMG bias did "persist into residency and fellowships and even as an attending physician," as ascertained by Smriti, Inder and Geeta. Govind like Khushi admitted that, "the first-generations Indians don't really have too many choices. I am in the committee to select residents. And the cut off point in most residency training programmes is 90-95 percentile in USMLE for foreign graduates. If you score 95 percentile, you still don't have a choice. That is the story of about 90-95 percent of the cases…I know one resident, and he had 99 percentile, and he did not get a residency position with 99 percentile and you will not expect any American graduate to not get any position even if he got 85 percentile. That is how they are discriminated."

Puneet explained that, "the standards for the people that are led into the country to train are a lot higher than the people who actually trained here,

graduate and become doctors. As soon as you get labeled as a foreign medical graduate, it's almost like FMG is a bad word…they get type casted as an outsider, and whoever is hiring doesn't want an outsider...and because of that I do think that they are not hired as often or discriminated upon…" In fact he argues that racial discrimination against FMG's stems from their different "clothes", "body language", "food", "Indian names", "skin color", and "facial features." Moreover, "accent" and the "language barrier" that follows plays a predominant role in nurturing discriminatory behavior towards FMG's and "pulling back" by other clinicians and the administration who are "harder" on them, as widely acknowledged by Jagat, Deepika, Sadia, Urmila, Vaishali, Devika and almost all of the other second-generation Indian physicians. Sadia explained how an accent leads to differential treatment of physicians at the workplace, "suppose I am on a call like a surgery service or a radiology service and I am gonna say that this is what is going on with the patient, and this is what I think the patient needs, I think that people who have an accent, are a little bit more easily dismissed, and their findings and their conclusions, their assessment of a patient's needs is a little bit more easily dismissed because they have an accent…there are people in my program who feel that because they are South Asian, Middle Eastern, like that part of the world, they are given a harder time than their white counterparts." In another instance Dravid reveals how racial discrimination against FMG's occurs under the garb of accented speech problems, "like in residency there was a guy [first-generation Indian] that was having some trouble, and I think it was more than just the cultural differences and

the language barrier [it was racial discrimination]…ultimately got kicked out of the residency and so a lot of people thought that it may have something to do with the language barrier but for me personally I never really experienced it that way."

As a consequence Reema conceded that, "even though they may be extremely qualified, they may have the highest scores on the tests, and they maybe top of their class…they are not readily brought into the more competitive residencies in the U.S." And since FMG's are considered "not as knowledgeable as U.S. graduates and they are lesser in academic merit," as expounded by Ashrit and Urmila, they often have to "outperform others" and "tend to put in much more efforts," as acknowledged by Mukul and many first-generation Indians. Moreover Kajol revealed that often they "end up either not getting residencies, and they end up having to do something else…often times they won't get a residency in the specialty that they want, so they end up having to change their specialty to something that they don't necessarily want to do." In fact Ridhima and Tripathi admitted that FMG's "have to be two steps ahead" and be "clearly above the norm" than American graduates. While Aman and Vineet argued that it was "way harder" for FMG's to be admitted to surgical branches, Gastroenterology, Cardiology, Orthopedics, Dermatology, and Radiology; unlike Pediatrics, Family Medicine, and sometimes Internal Medicine.

Ridhima who did do research at an ivy league U.S. Medical university revealed that, "when the time came, to offer me a position there, even though the

chairman was very willing to do so, three of the senior faculty's, two of which were my mentors, they strongly opposed, even though they were supposed to be my mentors, and help me with my research and my career, because there has never been a foreign medical graduate in their program and they don't want to start a precedence of that. It was clearly a bias there. And the chairman he himself said that there are many talented foreign medical graduates, who come to this country and I see them like you working hard, but you guys have to work twice hard, and prove that you are worth it, even though you are clearly worth it…I was already a green card holder." Mihir argued that, "even after you get trained in U.S. system, and complete your residency, when you apply for fellowship positions, the same thing happens…you get turned down instantly from competitive programs…and they would interview other people, American graduates from your program, who may or may not be as meritorious as you were…you know its actually a vicious cycle for foreign graduates…when they apply to residency programs, good residency programs do not accept them, because they are foreign graduates…so most foreign graduates even when they are good, land in average, below average, mediocre programs…now you enter such a bad loop that now because you are from an average residency program, you go to a below average fellowship program specially applying to a competitive fellowship. So now you are a foreign graduate from an average residency program, from a below average fellowship program, and you look for an academic position, you probably wont get it anywhere, except at a below average fellowship program, so your academic career nose dives. And if you look into the

U.S. system, most foreign graduates do not join academic practices probably for this reason that they will not flourish in academic practices, because of the way the system is biased against them." In fact when it came to rank advancements, many physicians like Nakul agreed that Indian FMG's "would have a harder time getting promoted in the workplace," unlike U.S. graduates.

The visa status of FMG's also emerged as an important ground on which discriminatory practices against them were constructed. Kavya felt that first-generation Indians, "try not to ruffle peoples feathers as much with the fear of maybe some kind of retaliation because of their race'" and were "very timid" and "low profiled," as admitted by Ridhima. Mukul acceded and explained that FMG's on a visa when "given an extra shift…you won't protest as much as a U.S. citizen would do because you would like to keep everybody pleased because of course they are sponsoring your visa." Likewise Prakash as did Vicky felt that "the J-1 waiver thing. It is a foreign medical graduate thing. You are a foreign medical graduate, we have a whole set of jobs for you that nobody else wants. If you do that then I will give you a chance at the green card. That's discrimination. Why cannot anybody who is coming in legally have the same opportunity?"

In other incidents Ridhima recollected that some attending physicians would be "rude and mean" to FMG's unlike other American residents. This also stemmed from the widespread anger and fear at the workplace that FMG's "are taking slots away from other white deserving American students," as revealed by

Aarti and Kate. In fact Shashi revealed that, “even in FMG’s there is a different classification, so if you are from Canada, or if you are from Europe, you are considered okay on some level. But then if you are from Asia [there is a strong bias].” A senior faculty in administration, Vanessa acknowledged that FMG’s “lot of times fill the undesirable spots…people expect you to prove yourself and that is not the attitude with which you [treat other USMG’s]…I think people are biased against people that seem foreign.” Likewise Maggie a program director admitted that, there have been people who told her “you don’t want your program to have more than 5% [FMG’S]. I think one or two years okay…I try to make it around 10%. And there were people who questioned me that were dangerous for the programs reputation…I think that is something that you hear, that the weaker programs have to fill with IMG’s.”

Second-generation residents like Nupur argued that FMG’s usually ended up repeating a lot of the training that they had and were at times already well-versed in the specialty than U.S. trained graduates like her. Omi, a second-generation faculty too found foreign graduates to be “some of your better doctors that you have, because they know how to actually examine a patient, whereas our American graduates don’t know how to examine a patient. They rely too much on technology…since I am on both cultures, I don’t think that its justified, because you are making judgments on people before you even see them [FMG’s] at work.” While Ravindra , a second-generation chair in pediatrics revealed that, “there is a mass of Indians or people from the Indian subcontinent”

who “have green cards,” and have passed requisite U.S. tests, “are completely qualified” “that simply can’t get a residency position.” He concluded that, “there are a lot of disgruntled, disenfranchised physicians that could provide good medical care in underserved populations that are driving taxicabs right now. Absolutely, I know them. That’s a bit of a waste. But there is an increasing xenophobia in the United States after 9/11. And more recently xenophobia is unbelievably rampant fuelled by politics that is convenient and by ill-conceived people as well. I don’t think it’s going to help in allowing people to break into that circle.”

FIRST-GENERATION VS. SECOND-GENERATION INDIAN PHYSICIANS

A majority of the physicians in the study reported to have experienced tensions between the first and second-generation Indian physicians in their hospital workplaces. Quite a few first-generation Indian physicians interviewed in this study felt discriminated by their second-generation counterparts at the workplace on various grounds. While Pamela felt that second-generation Indian physicians “underestimate” workplace capabilities of first-generation Indians; Kanika and Anandita found that they had “superior”, and “very cavalier attitude” towards them and were “prejudiced” against first-generation Indian physicians whom they referred to as “fresh off the boat.” Gauri felt “uncomfortable being around them,” and Kanav recalled that “they [second-generation] don’t want to talk about India [at workplace conversations], they don’t want to talk about things about India, because they don’t want to be called Indians.” Moreover, Saurabh

felt that there was a “level of disdain” among second-generation Indians for the first-generation, as did Avtar and his wife who had to face “ethnic profiling” and had to dispel the “preconceived negative notions” that second-generation Indians at work had about them. Similarly Prakash found that “they [second-generation] may joke about the first-generation Indians, ‘oh you know the thick accent’ or certain things that are done here [in U.S.] in polite circles, and they [first-generation] don’t know any better…it is a cultural transplantation which is inappropriate here [U.S.] but it could be appropriate over there [India].”

It was my subsequent interviews with second-generation Indian physicians that helped explain the reasons behind the workplace tensions regulating the professional relationships of first and second-generation Indians. Second-generation Sudeep acknowledged to have experienced the “animosity” and “discrimination” the second-generation had towards first-generation Indians at work. Nandita attributed this to the fact how, “in all spheres there is a huge tension between first-generation and second-generation people…any doctor that has a foreign degree is seen as inferior…in some settings…at the resident level…not only does the same social separation outside of work occur [inside of work]…but also inside of work you wanna be seen as an American doctor with an American degree. So to a certain extent you kind of distance yourself a little bit from the people who are foreign medical graduates…you want people to know that you are in the same sphere as the white doctors and are just as capable of being the chief of a division and have none of the disadvantages of a foreign

medical degree." Likewise Inder felt that "we [second-generation] don't wanna be associated with them [first-generation Indian physicians at work]. I think it's because of the negative connotations associated with being a foreign doctor. I don't want people to think I am a foreign trained doctor. I want people to know I have graduated from a U.S. medical school."

Similarly Bhema confessed that he was "a little put off" by first-generation Indians for the same reasons. Nandita felt that the "unspoken assumption" and the "undercurrent" that second-generation Indians had about their U.S. medical graduate status was further "reinforced by the fact that they are preferred in residency, fellowships, etc." as compared to FMG's. Sadia as well admitted to having a "lack of respect" for Indian FMG's and felt certain "defensiveness" towards them since she feared that they perceived her "as Americanized" and assumed that they were like her parents, "very traditional, very close-minded." In fact familial inter-generational tensions experienced by second-generation Indians at home colored their professional interactions and tarnished the way second-generation physicians perceived their first-generation counterparts at work. As Omi explained, "…people who immigrated in the seventies and sixties came with the values of India in the sixties and the seventies. India continued to change, these people didn't, and they stayed with the same values. So they implemented those values on the second-generation of people. We then grew up with these values plus the values of the changing America…We had a conflict

with how we were supposed to be at home, versus how we were supposed to be at school, or at work or all these things. And you try to cling onto that."

Ajay, a second-generation senior faculty argued that the inter-generational conflict at work in fact mirrored the 'identity crisis' experienced by the second-generation Indians in the United States. With first-generation Indian parents being very influential in the lives of their children, the clash between them and their second-generation children causes a lot of confusion in the lives of their children, which is why second-generation Indians are often called ABCD's. American-Born Confused Desi or ABCD for short is a derogatory term used to refer to Indian Americans born in the United States. ABCD or American-Born Confused Desi has become a polarizing factor in the South Asian Diaspora in the United States, between the first-generation immigrant parents and young South Asians of second or latter generations. The term 'Desi' comes from the word 'des' (homeland) in Sanskrit and Hindi meaning 'of the homeland'. Among South Asian Americans, the term may be considered divisive, as first-generation South Asian Americans use it to criticize the Americanization and lack of belonging to either South Asian or American culture they perceive in their second-generation peers or children. Ajay explained:

"…the second-generation person wants to date, wants to meet other people from the opposite sex, wants to interact. And the first-generation Indians kind of stay in their own society, and never become American. They become kind of Indian from the 1960's and 1970's here in America. So they [second-generation Indians]

develop this negative view of all first-generation Indians, because they have this resentment towards their parents…So I think what happens is when they enter medical school and they see someone who is a first-generation Indian coming, they transfer their attitude towards their parent onto this person unfairly…I wish they would not do that…"

The social distancing at work between these two sets of physicians was also exacerbated by workplace insecurities of second-generation physicians. Vikas acknowledged, "first-generation physicians may work harder, longer hours, or taken on more responsibilities, patient care and be willing to do that. I think I see that. I do see that where the physician is just working all the time, and not even coming home basically…in terms of work that looks great…." Aarti recalled, "often times it's the Indians [second-generation] that make it more difficult for them than anybody…you would never see the second-generation go out of their way to help them [at my former program]…there is some level of fear I think among second-generation Indians that we feel that they [first-generation] are going to be smarter than us and they are gonna have all the right answers. There is less likelihood of working with them and helping them out…because eventually they are going to outshine you out."

Moreover Anandi felt that first-generation Indian men had a "paternalistic attitude that they can be in control and command of what you do and how you do." Likewise Inder found his first-generation Indian attending physician in

medical school and residency to be "more strict, they were more difficult or more hard on the Indian students…they kind of held you to maybe a higher standard or if you would be in a group situation it seemed like they would always ask the Indian student the question or quiz them or we used to call it pimping..." Similarly, Kavya faced "more pimping[7], higher expectations, that you should know more, you should do more, you should be right more often than he [first-generation Indian attending] would on the non-Indian fellows…we always sort of attributed to 'oh he's just sort of typical Indian uncle who like thinks that they know everything'… and I think deep down they want you to do better…I think that there is this innate feeling of I have to make this person succeed and I have to make them the best and so the way to do that is to push them and push them to be the best. And I don't think they know how to do that in a nurturing and friendly manner. I think its more like, I am challenging you by asking you hard questions, and expecting you to do above and beyond other people," unlike in the United States where she felt the faculties "hand hold a little bit more" and "spoon feed" their students.

In addition Sumit like many other second-generation felt that "the first-generations think that the second-generation has it a little bit easier…by being born and raised here, being an AMG (American medical graduate)…there might be feelings of resentment about how easy I have it compared to them." Inder and

[7] Pimping is an age-old practice in medicine in which senior physicians grill their medical students with questions to make them into better physicians. Pimping of medical students often takes place during rounds when physicians and their students are examining hospitalized patients (Lerner, 2006).

Arjun found that first-generation Indians felt that the second-generation physicians “had everything kind of lined up on a silver platter,” and were “spoilt”, despite the second-generation medical students having “over a hundred thousand dollars in debt” on graduating from medical school unlike their first-generation counterparts in India. Reema recollected how when she was a resident, “there is one particular cardiologist who made a couple of comments, ‘it must be nice just to walk in and get a surgery residency.’” Likewise Krutika felt that first-generation Indians thought, “there is no reason that second-generation Indian shouldn’t be graduating from Harvard and Stanford. They have all become Americanized and they don’t care about Indian values.” In fact Daya reminisced how during an interview she was asked by a first-generation, “are you trying to come here to run away from your parents? A lot of Indian kids, they don’t wanna be around their parents.”

Finally, as Inder and Arjun explained, the different “thought process” and “cultural mentality” of the two groups makes for a “barrier” at the medical workplace. Khushi elabaorated, “within the workplace… sometimes there is this tacit assumption between people of the same ethnic group [first and second-generation Indians] that there is some connection or that there is a sense of kinship…or like a paternal or maternal quality occasionally…it bothers me when it’s presented in a way that’s divisive towards other people in the group…the level of assimilation in most second-generations is…in lot of respects indistinguishable from any other group whereas first-generation still there is a

tremendous rift." Bhema too found that the first-generation physicians "tend to be more clickish, sort of more expecting support simply on the basis of assured ethnicity than second-generation, they don't." Moreover, Aarti felt that since the second-generation Indians "want to fit in [at the workplace culture] so they find it difficult to interact with the first-generation Indians" who are made fun of or discriminated against by other non-Indians. In fact Bhema acknowledged how sometimes among the second-generation Indians "there is a little bit of an embarrassment factor...when you see somebody from what everyone else would view as being from the same background as you is not acting in a professional manner, you sometimes feel embarrassed on their behalf."

DISCUSSION AND CONCLUSION

In American medicine, research has consistently shown disparities between the health experiences of non-Hispanic whites and racial minority groups (Shervington, 2000), but the practice of racial discrimination *within* the profession is less well acknowledged. With the recruitment and retention of minority faculty in U.S. academic medicine being important, there is less research on their 'self-reported experience of racial and ethnic discrimination at their institutions' (Peterson, et al., 2004:259). My findings show that individual Indian physicians may achieve social mobility and gain economic parity in the United States, but only as exceptions to the rule, as evident by racial discrimination in promotions, referral patterns, and the "glass ceiling" faced by them "when it comes to really rising to the top." What's more, racism is not a

static phenomenon, but subject to change and transformation. My research shows how in contemporary America racial attitudes are likely to be symbolic (Pettigrew, 1994; Sears, 1988) following the departure of 'traditional legal segregation' (Feagin and Eckberg, 1980:18) and racial practices are informal, subtle and 'manifested covertly' (Bonilla-Silva, 1997:468; Bonilla-Silva and Lewis, 1997; Wellman, 1977). Yet, racism is often understood as overt in practice. This perception fails to take into account situations in which 'racial practices are subtle, indirect or fluid' restricting the possibility of analyzing racial phenomenon that are not overt (Bonilla-Silva, 1997:468). Moreover, recent research on racism in the United States finds that 'racism is more than just a personal attitude, it is the institutionalized form of that attitude' (Feagin and Sikes, 1994:3). This can entail 'conformity to the expressed prejudices of relevant others, to the discriminator's perception of the desires of others, or-and this is crucial in bureaucracies – to the "standard operating procedure"' (Feagin and Eckberg, 1980:10) . Besides, experienced and prejudiced discriminators may intentionally and more robustly use mechanisms of indirect discrimination to turn down minority applicants 'because of organizational regulations' (Feagin and Eckberg, 1980:14). Organizations often act as gatekeepers of acceptance and rejection of members by maintaining social boundaries that signal membership and exclusion (Barth, 1969). Research shows that an extended period of institutionalized discrimination against Asian American immigrants in the United States severely curtailed their opportunities in the nineteenth century (Kitano and Daniels, 1998;

Sakamoto and Kim, 2003). Zucca (1979) in fact claims that discriminators who act with institutional backing can be more harmful than those who do not.

However patterns of institutionalized discrimination are shaped more by the desire of the dominant group to safeguard it's position than with it's resentment of minorities (Feagin and Eckberg, 1980). Shibutani and Kwan (1965) argue that a system of racial stratification is secured partly within a moral order that persuades the dominant group into believing that its privileges stem from natural differences from the subordinate racial group. Competition and natural selection subsequently are seen as pushing minorities and those categorized as 'others' into the less desired social locations and economic niches. This is evident with the returns on education being lower for first-generation Indians, who are paid well but less than whites in medical and other professions in the United States (Barringer and Kassebaum, 1989) and by the lower rate of promotion of minority faculties compared to their white counterparts in medicine (Fang, et al., 2000; Palepu, et al., 1998). Similar outcomes were reflected in my research findings with quite a few first-generation physicians perceiving discrepancies in their salaries when compared to their white counterparts, and a large number of second-generation physicians finding race in a dominant role in regulating their promotions in academic medicine. Moreover, first-generation Indians are not fully accepted either by the dominant group or by their own ethnic community in the United States. This is evident in the hostility and resentment of mainstream America towards successful Asians (Ahmed, 1957; Bhatia, 2008;

Kibria, 2002) and in the social distancing and "ethnic profiling" of first-generation Indian physicians by the second-generation Indian physicians in the United States, as my study found. First-generation Indian physicians are often seen as competing with other racial groups for the same spots. As my research found, they are also seen as competing with second-generation Indian physicians, who are unaffected by the FMG stigma, rigid visa regulations, and accent discrimination, and who offer more promise to prospective employers.

To suggest that social incorporation, just requires "'culture shedding' or 'some behavioral shift' or the 'unlearning of one's previous repertoire'" (Bhatia, 2008:37) overlooks the multiple, contested and sometimes agonizing processes involved in gaining social acceptance at the workplace. The attacks of 9/11 in the United States further created a 'heightened state of racialization' for many South Asian physicians in the United States, which ruptured their sense of place, race and incorporation into the American society (Bhatia, 2008:29; Maira, 2004; Purkayastha, 2005a). Although the "otherness of the Indian physician" is at times enjoyed by their patients, my findings confirm that 9/11 made Indian physicians, first and second-generation both, increasingly vulnerable in their interactions with their patients. In fact Dravid revealed that when patients don't get "abused medication like pain pills, and sedatives" by their physicians, they often make comments about physicians of Indian or middle-eastern descent and "…basically reference Al-Quaeda and things like that and try to say that 'Oh they are probably from there'…because the physician didn't give them what they wanted".

Moreover, for Indian physicians, social incorporation is affected by the inter-dependency required in the medical workplace, and thus on occasion is affected by abuses, yielding differential results for the established members and the newcomers.

In addition, my findings identify three chief reasons contributing to workplace tensions between the first and second-generation Indians. First, physicians migrate from India to the United States with 'beliefs' acquired in their home country. The socio-cultural dispositions and "a sense of hierarchy" they acquired in India continue to affect their behavior and representations in the United States, leading to discrepancies and tensions at their U.S. workplaces. Second, tensions at the workplace between first and second-generation Indians are also fuelled by the foreign medical graduate bias in American medicine against first-generation Indians and the competitive context that follows, which varies from competing for fellowship spots to competing for something as minor as proving oneself to be more hardworking. Tensions also emerge from the struggles and strategies physicians engage in to ward off their own insecurities, discomforts and perceived threats. Third, tensions also emanate at work between the two generations from efforts to maintain social distance (Bogardus, 1925) from each other in order to regulate the degrees of understanding and intimacy characterizing their social relations. My findings suggest that second-generation physicians transfer familial inter-generational tensions experienced at home to the workplace, affecting their interactions with first-generation Indian physicians.

My study raises three issues that are new for research on U.S. racism: (1) the focus on medical racism in the United States; (2) racism against new immigrant groups, particularly skilled professionals, such as temporary H-1B and J-1 visa workers; and (3) second-generation Indians. With the healthcare workforce in the developed world becoming increasingly dependent on immigrants from the developing world, more research is needed to understand the interaction of recent migration of skilled personnel with developing racial/ethnic relations in U.S. workplaces. Such studies will also have policy implications for the flow of professional immigrants between the developing and the developed world. Undoubtedly, the in-depth investigation of discrimination among practicing physicians is going to be a long, contentious and arduous endeavor. However, the U.S. population is becoming more and more diverse each day. Issues of equality, justice and cultural compatibility will become ever more important. Moreover, given the significant impact race can have in molding and restricting the career/migration trajectories of Indian physicians in the United States, conceptualizations that recognize and inform the impact of discrimination against skilled professionals are imperative.

Table 2. Race and Ethnic Origin of Resident Physicians on Duty in ACGME-Accredited and in Combined Specialty Graduate Medical Education Programs, December 31, 2009

Specialty	**Whites, N (%)***	**Asians, N (%)***
Dermatology	764 (71)	203 (19)
Family medicine	4961 (52)	2369 (25)
Internal Medicine	8966 (40)	8822 (40)
Orthopedic surgery	2571 (76)	454 (13)

* Residents from other races and ethnicities constitute the rest.

Source: (Brotherton and Etzel, 2010)

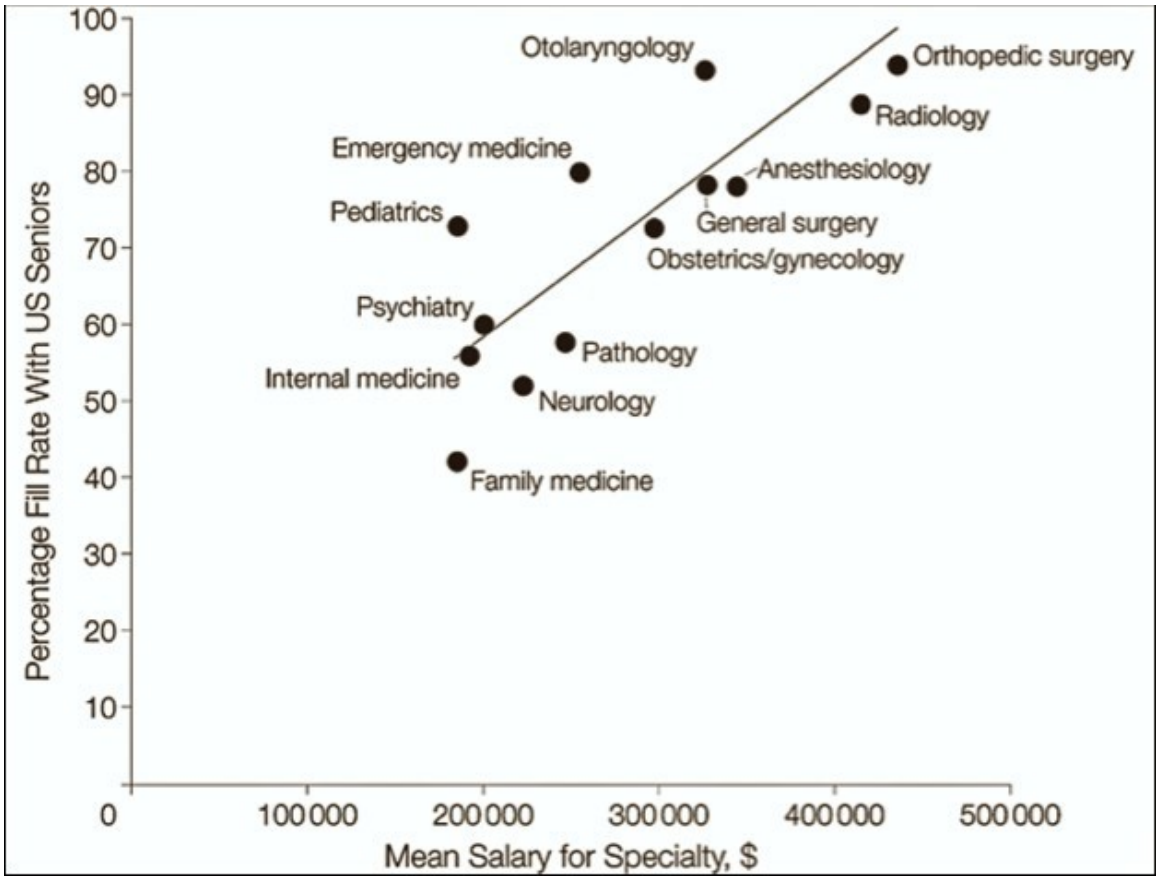
Table 3. Resident Physicians on Duty in ACGME-Accredited and in Combined Specialty Graduate Medical Education Programs, December 31, 2009

Specialty	**USMDs, N (%)***	**IMGs, N (%)***
Dermatology	1024 (95)	40 (4)
Family medicine	4145 (44)	3746 (40)
Internal Medicine	10855 (49)	10066 (45)
Orthopedic surgery	3238 (96)	97 (3)

* Residents trained in Canadian and Osteopathic medical schools constitute the rest.

Source: (Brotherton and Etzel, 2010)

Figure 1. Percentage of Positions Filled with US Seniors Versus Mean Overall Income by Specialty



Source: (Ebell, 2008)

Chapter 4

THE INHERITANCE OF LOSS[8]

GENDER INEQUALITY IN AMERICAN MEDICINE AND THE LITTLE BROWN WOMAN

"…There is almost a racial hierarchy that exists. If for the same job there are four-five options available, and it's not just the race, it's also gender. So if there is a white male available, that will always be the number one choice. So if you have to go and make a rank order list, in general white male gets preference, and then black male second, then white female, then Indian male, then black females, and then everybody else. And Indian female comes really at the bottom. And sometimes equal to or even below the Hispanic. This is just the way they work. And it does not matter whether the person making decision up top necessarily is black or white or Indian.**"**

Piya Jaiswal, In-depth interview, U.S. Southwest, June 2010

Gender constitutes 'an emergent feature of social situations: both as an outcome of and a rationale for various social arrangements and as a means of legitimating one of the most fundamental divisions of society,' often tailoring the limits and the choices of women physicians in the United States (West and Zimmerman, 1987:126). A gendered hierarchy that privileges hegemonic masculinity and subordinates or excludes women is embedded within the

[8] The title 'The Inheritance of Loss' is borrowed from Kiran Desai's novel (2006).

‘underlying assumptions and practices that construct most contemporary work organizations’ (Acker, 1990:147). This is achieved by the reproduction of complex inequalities within organizations through gendered relations at work which pattern ‘advantage and disadvantage, exploitation and control, meaning and identity’ in terms of a distinction between men and women (Acker, 1990:146).

Gender is a fundamental constituent of ‘organizational structure and work life’(Britton, 2000:419), ‘present in [its] processes, practices, images and ideologies, and distributions of power’ (Acker, 1992:567). And so called ‘rational-technical’ organizations, projecting a gender-neutral, control system are actually ‘built upon and conceal a gendered substructure’ (Acker, 1990:154). This is evident in the organizational roles that ‘carry characteristic images of the kinds of people that should occupy them’ (Acker, 1990:143). For instance, managerial positions in organizations require a ‘masculine ethic’ that ‘elevates the traits assumed to belong to men with educational advantages to necessities for effective organizations’ (Kanter, 1975:43). As Lindsay, a program director in medicine admitted how “it’s not typical they think for a woman of color to be in the position of power, that’s not the prototype powerful person in the United States. It’s like I said a white man in his fifties or sixties.” Descriptive stereotypes further reinforce these widespread beliefs by compartmentalizing different behaviors and capabilities with either women or men (Benard and Correll, 2010; Berger, et al., 1972; Burgess and Borgida, 1999; Heilman, et al., 2004). Technical skill

becomes linked with masculinity (Britton, 2000; Cockburn, 1983 1985; Hacker, 1990; Wright, 1996) and agent qualities like intelligence, assertiveness and competence that are identified with management and workplace accomplishment are associated largely with men (Acker, 1990; Benard and Correll, 2010; Britton, 2000; Eagly and Karau, 2002; Heilman, 2001; Pierce, 1995; Rudman and Glick, 1999). While communal qualities of empathy, selflessness and warmth are associated with women, who are considered more suitable for communal occupations like nursing as opposed to managerial roles that are relegated to men (Benard and Correll, 2010; Burgess and Borgida, 1999; Heilman, et al., 2004). This compartmentalization of workplace skills by gender is further fortified by proscriptive and prescriptive stereotypes on what men and women '*should* or *should not do'* (Benard and Correll, 2010:619; Burgess and Borgida, 1999; Eagly and Karau, 2002; Heilman, et al., 2004; Rudman, 1998). Thus discrimination of women physicians at the workplace is centered around these stereotypes and happens when women are viewed as less competent or unable to execute a 'masculine-typed job' (Benard and Correll, 2010:621; Eagly and Karau, 2002).

Women who enter "traditionally 'male' professions" like medicine have to face negative stereotypes that suggest "they are not 'real women'" (Williams, 1992:264). As a result, women even when successful in a masculine-typed job face a 'double-bind' (Benard and Correll, 2010:620) by being judged negatively (Benard and Correll, 2010; Burgess and Borgida, 1999; Ridgeway, 1982;

Rudman, 1998; Rudman and Glick, 1999), and viewed as ‘hostile’ (Heilman, 2001:667-68), ‘less warm and nurturing’ (Benard and Correll, 2010:620).

Acker (2006:443) describes inequality in organizations as ‘systematic disparities’ and differential access ‘between participants in power and control over goals, resources, and outcomes; workplace decisions such as how to organize work; opportunities for promotion and interesting work; security in employment and benefits; pay and other monetary rewards; respect; and pleasures in work and work relations.’ For instance, women-dominated occupations and whole subsections of U.S. medicine with a high rate of female physicians ‘continue to be those with lower standing in terms of career opportunities, income, and prestige’ (Heath, 2004:412). Research shows that women in academic medicine earn constantly less than their male counterparts with similar productivity (Ash, et al., 2004). Women are required to ‘work harder to compete, have less status, get passed over for promotion’ (Dobson, 1997:80). In particular the *glass ceiling* in U.S. academic medicine is often seen as contributing to ‘women’s lack of advancement into leadership positions despite no visible barriers’ (Carnes, et al., 2008:1453). The present academic structure, which actually developed at a time when men comprised its sole members, perceives women as ‘having less leadership ability and less competence, and when women exercise assertiveness or try to assume leadership they have to work harder to get attention and they receive more negative reactions’ (Hatala, 2003:542).

Academic medicine in particular mirrors this dichotomy between the numerical strength of women in the field versus their underrepresentation in leadership positions and among tenured faculty (Bickel, et al., 2002; Carnes, et al., 2008; Kass, et al., 2006). Studies show how systematic disadvantages like absence of effective mentorship, harsh and sexist work environment, and inadequate job opportunities, limits the career advancement of women in U.S. academic medicine (Carnes, et al., 2008; Carr, et al., 2003; Kass, et al., 2006). Women are more apt to engage in 'institutional housekeeping' and be educators and clinicians as opposed to being on research-based faculty tracks, which lead to management positions (Carnes, et al., 2008; Sharon, et al., 2004). For instance, in 2005, 'only 32% of medical school faculty, 15% of full professors, and 11% of department chairs' were women in U.S. academic medicine, whereas in academic surgery 'women represented 16% of the faculty and 6% of full professors, and only 2% of department chairs' (Kass, et al., 2006:179).

Even though women have entered previously male dominated occupations like medicine, what seems to be a reduction in segregation may actually be its reconfiguration (Acker, 2006). For instance, women physicians are likely to specialize in pediatrics than surgery, which still largely remains a male domain (Acker, 2006). But women comprise 10% or less of department chairs in psychiatry and pediatrics, fields in which women have constituted at least 50% of it's workforce for the past two decades (Atre Vaidya, 2006). Women headed only

20% of NIH (National Institute of Health) Institutes in 2006 (Carnes, et al., 2008), receiving lesser budget increase, than units headed by men (Mazure, et al., 2001). Although studies have shown that women have been more transformational and effective than men in leadership positions, 'from producing high-quality work to goal-setting to mentoring employees' (Bass, et al., 1996; Eagly, et al., 2003; Sharpe, 2000). But when interested they are frequently denied leadership positions in academic medicine (Wright, et al., 2003). Even when women attain management positions, research shows that they are closely scrutinized (Bendl and Schmidt, 2010).

Moreover, studies acknowledge that household responsibilities exacerbate the career obstacles of many women, and women continue to face added difficulty in the workforce if they are mothers of dependent children (Budig and England, 2001) or even when married. William Osler, popularly known as the 'father of modern medicine' in the United States saw family attachments of women in medicine in the nineteenth century as throttling their professional career (Palepu and Herbert, 2002). Even now academia as a choice of profession for female physicians makes 'no allowance for the clash between the biologic clock and commitment to research' (MacLeod, 1996:709). U.S. national surveys find that female medical-school faculty with children have less research funding and secretarial support from their institutions when compared to male faculty with children (Carr, et al., 1998). In fact U.S. studies show that women plastic surgeons, gastroenterology trainees, and cardiothoracic surgeons were

more likely to remain unmarried, or be childless (Arlow, et al., 2002; Dresler, et al., 1996; Halperin, et al., 2010), and shouldered the majority of the household responsibility unlike their male counterparts.

What is worse, absence of female role models, discrimination by patients (Firth-Cozens, 1990), and psychological abuse (Cook, et al., 1996) are commonly experienced by female residents and faculties in training programs in the United States. Reports of sexual harassment or discrimination also differ substantially by gender, and are a fairly common experience among women medical students in the United States who are known to report sexual harassment as much as four times more often than men (Baldwin, et al., 1991). While 77 percent of medical women faculty in the United States experience gender-based discrimination and harassment (Carr, et al., 2000), notable in male dominated surgical specialties (Carnes, et al., 2008). An ongoing U.S. study of physicians relates the workplace experiences of mothers who graduated before the passage of the civil rights legislation, to their daughters who graduated medical school a decade after gender and racial discrimination at the workplace was outlawed (Shrier, et al., 2007:883). It finds that ‘mothers and daughters reported similarly high rates and severity of sexual harassment before medical school, while in residency/fellowship, while in practice/work setting, and by teachers and supervisors. Daughters reported higher rates of harassment during medical school and by patients, mothers by colleagues’ (Shrier, et al., 2007). It is

not surprising therefore that most women physicians believe medicine to be a male dominated profession.

Although scarce, studies also testify to substantial differences in perceptions for women and minority graduates, compared to white male graduates, regarding experiences at medical school and the professional medical environment in the United States (Gray, et al., 1996). But given the already troubled waters for women physicians in the United States, there is strangely negligible research investigating how women physicians from ethnic minorities fare in an essentially white male dominated medical environment. In addition to gender, socially categorized indicators such as race, accent, nationality, and religion (Rumbaut, 1994) play an indispensable role in curtailing the occupational mobility of women of color. More so, when accompanied by discrimination and prejudice (Rumbaut, 1994) as a result of which their 'physical features become redefined as a handicap' at the workplace (Portes and Zhou, 1993:83). Research shows that racial and ethnic discrimination in U.S. medicine has had adverse effects in the advancement of minorities into leadership roles (Carr, et al., 2007; Fang, et al., 2000) similar to under-represented minorities (Petersdorf, 1994). Minority faculties report lower levels of satisfaction (Palepu, et al., 2000), and are more likely to leave their academic careers (Hadley, et al., 1992). Similar outcomes were found in studies that investigated the biases and barriers faced by Asians, foreign-born faculty and other minority physicians in American medicine (Nunez-Smith, et al., 2009; Pololi, et al., 2010). Furthermore, first-

generation women physicians from ethnic minorities face a triple bind in American medicine, with the addition of the pervasive foreign medical graduate (ECFMG) bias against them to the existing racial and gender discrimination that they encounter.

RESEARCH QUESTION

In the following pages, I argue that workspaces of Indian physicians in the United States are significant social spaces for the perpetuation of gendered and racialized norms in the workplace. I found similarities, as well as differences, between the experiences of first and second-generation Indian women physicians in the study. Although race plays a substantial role in shaping the workplace trajectories and outcomes for both sets of physicians, the foreign medical graduate bias in American medicine acts as a triple bind for first-generation women along with gender and race. Moreover, discriminatory family attitudes at home further impede the professional trajectories of these Indian women. I focus on three aspects: (1) gender discrimination against women physicians of Indian origin, (2) discrimination by patients along the lines of gender, as well as race, and religion; and (3) how discrimination at home influences and shapes the professional and personal trajectories of Indian women physicians. I then argue that the experiences of Indian women physicians who are second-generation Indian Americans as well as foreign medical graduates (FMG's) are missing from the literature concerning migration, gender and race. Lastly, I will explain how a sociological study of these physicians can

help us understand the operation of gender and race at the medical workplace in new and important ways. The sections which follow address findings of the three major issues that emerged in my interviews.

GENDER DISCRIMINATION IN AMERICAN MEDICINE

A majority of the Indian women physicians who were interviewed for this research experienced gender based discrimination at all levels at the medical workplace- as residents, faculty, and in promotions to positions of power. In terms of gender-based discrimination, 78% of the women respondents reported that women physicians have to overcome extra hurdles at work, particularly when it came to positions in power (75%). Again, 1/3rd of these respondents reported "absolute" or "definite" bias in positions of power based upon gender. Several examples of these reports are given in this section to illustrate and elaborate on these cases.

Shweta, was asked inappropriate questions at her residency interviews unlike her male colleagues, "I was asked whether I was single, whether I was seeing somebody, whether or not I was serious or married, and if there was any possibility of me having children. These are personal. And in fact the ACGME [Accreditation Council for Graduate Medical Education], ERAS [Electronic Residency Application Service] and all of those institutions will flat out tell you these are illegal questions, that are not supposed to be asked during an interview, but I was asked those questions." Preeti recalled how women

physicians unlike men who compete for residency spots, in particular surgery are often asked questions that they “are not supposed to ask in interviews, but somehow they slide it in there, about was she [another physician] planning on getting pregnant during the residency, completely inappropriate to ask those questions because you are not supposed to make decisions based on whether someone is planning on having children or not. And the fact that she was not married was a plus for them.” Padmini felt that she had to work harder to get the same things, as compared to male residents. “What I mean by that is that it’s easier for people to write us [women] off as, ‘Oh maybe she is not as smart,’ and you have to work extra hard to appear that way. Whereas the guys can run around joking, and say stupid things all day, and I don’t think they get perceived like that. So I think that you have to be extra careful about the way you come across, being a woman so that you are taken seriously.”

Residency training also differs in the way male and female residents are treated in the program. Tanuja who is in pediatrics, a branch known to be dominated by women physicians often jokes with her colleagues about “how the males and the females are treated…the men have a lot more strength to do the procedures, and so you would be given a hard time because you can’t carry that set of equipment as quickly because it maybe heavier or cumbersome, or do the procedure, like there is a certain maneuver or certain way because your hands are small, because you are a female.” Shweta also felt that when she was in training, “a male resident could make a mistake and it was considered, ‘Oh, well

you were just trying to be aggressive,' or it was kind of blown off, but if a female resident made the same mistake, I have also seen her get reprimanded to a greater extent than that male resident would have…I definitely have also seen where male attendings have steered female residents away from maybe more labor intensive or other fields, because they feel like, 'Oh don't you wanna have babies, don't you wanna have a family one day, are you sure you wanna do something so stressful.' …There is definitely a bias towards steering women into more thinking specialties, or ones that are maybe less time intensive, versus males where they are like, 'Oh you have got hands, you should do things,' and more procedure-oriented, or higher paying even within medicine."

SURGICAL SPECIALTIES AS DISCRIMINATORY FIELDS

In almost all of my interviews with men and women physician's alike, competitive procedure-oriented specialties and sub-specialties like general surgery, gastroenterology, neurosurgery, urology and orthopedics unanimously emerged as exceedingly discriminatory fields for women physicians. Their attendings and even their fellow colleagues usually tried to steer them away from opting for these specialties, fearing the probable family commitments of women that would impede them from committing the requisite time into these medical sub-fields. Considering the labor and time involved in these areas, these are also the higher paying specialties in American medicine where male physicians instead were encouraged at the workplace. While women physicians were steered more towards thinking or less time and labor-intensive specialties like

psychiatry, pediatrics, and family medicine. These branches were also less remunerative and non-competitive at the same time and less discriminatory racially and gender wise as reported by my respondents, because of the higher presence of women physicians and foreign graduates in these fields as compared to the surgical branches.

Rahul, a male faculty member felt that even now specialties like orthopedics are still “a boys club, and it’s a white boys club.” David remarked, “Surgical directors are a little more reluctant to take in a woman. If they go on a maternity leave they are gone a lot, they maybe are perceived as being more complaining.” Abhinav, a Urology resident resonated similar experiences as he explained, “I can’t think of one chair who is a female… I heard from a very close colleague of mine that one time a surgery professor told three women [2 Caucasian and 1 Indian], medical students that it was a little bit of waste of resources to train women because most of them are gonna quit or become part-time when they have kids anyways.” Shaurya who is a surgery resident shared that he has some female colleagues who “feel like they are being discriminated against in terms of their schedules because they are women …whereas they have been accommodating of other male physicians’ request at the same time.” While Shweta recalled her own experiences in surgery during her medical school rotations when she felt that, “there was like one female resident and she definitely got the short end of the stick…she constantly got berated, so people looked at her as not very bright, but I don’t know if it’s because, you know if you

have to tell somebody they are not bright long enough, they are gonna start believing." Likewise Nupur commented that neurosurgery, as a sub-specialty is "very hostile to women. I had a friend who was in neurosurgery and was asked if she was a lesbian because she wanted to be a neurosurgeon, she was treated with a very unwelcoming environment." Asha, a female surgical faculty concurred, "in surgery it [gender plays a role] does, because the vast majority of chairmen are still men and the vast majority of full professors in surgery are still men."

DISCRIMINATION AT THE WORKPLACE

When it comes to experiences at the workplace, Christine reminisced how her women colleagues who trained when she trained in the seventies felt that "there were some older male physicians who didn't feel women should be in medicine." U.S. medical workplaces as Inder explained carry "a strong bias against females" with the perception "that women can't put enough effort, enough time into their work." Even now Andrea feels that women in power "have to come to the table with their ducks in a row, versus a male who can come with the same credentials or not." Likewise at the workplace Shweta like Gaurav resonated similar experiences as a faculty when she described how "…there are comments that are made…one of my colleagues here recently…was pretty much like this why women shouldn't work… 'Most people [women] will work for a while but then they will come up with these illnesses so they can stay home, why go through that, just stay home…you took a job that could have gone to a man.'"

Avni also talked about the various stereotypes that men in the medical workplace propagate about women physicians, “And just the way that men in the workplace [physician colleagues] talk about women, about how they gossip and they are catty…all these stereotypes that people place with women, women are too emotional, we can’t think straight, ‘oh she might cry so I can’t say this to her.’” She also felt that women are paid less, often. Jennifer, a senior faculty in an administrative position agreed and suspected that “female physicians probably make less than their male counterparts; I think that probably a woman has to be better qualified for a job than a man who is applying for the same position, in order to get it.” Besides even when they do get the job, Uma felt that “there is a sense of arrogance, almost like they [men] should be able to kind of boss me around more than they would otherwise…I feel like a lot of non-Indian male physicians who are older kind of have that attitude at times too, it would either be Caucasian or [first-generation] Indian [male].”

What is worse, women physicians are also discriminated by female attendings and the nursing staff likewise. Tanuja felt that because her women attendings “had a hard time, because now there are more women in medicine, but when they were going through it, they probably had more hoops to jump through than we did, so…taking out their frustration that it’s easier on us than it was on them.” Similarly regarding the nursing staff, Tanuja like Deepti felt that

“even in the beginning the nurses [female] were much harder on us, and you sort of had to prove yourself to them before they would trust you.”

Lindsay, who has served as a faculty for twenty years and currently serves as the program director of internal medicine in a reputed university hospital confirmed, “I think that they [nurses] have a lot of latent hostility for physicians and they don’t like that physicians boss them around, and they don’t like the way a lot of physicians have treated them in the past. And they think that they can exert their will and be powerful, and they are more willing to do it with the women, because they are women…but also I think particularly if the nurse is single, they are trying to get in favor with doctors and hope that one of them might want to take them out, there is that whole thing going on.”

DISCRIMINATION IN PROMOTIONS

Even when it comes to positions of power in academic medicine Charak like Omi, Nakul and many other physicians divulged that, “management positions tend to go to men. And men have been usually in positions, they are more ambitious, they are more aggressive and those are values that tend to be wanted in a leadership position, and so generally men tend to interview better and they get accepted better, they get into the jobs more.” In fact Sudeep, a senior faculty revealed that women, “…are passed up for various opportunities, and part of it, has to do with kind of assumption people have that women don’t want to work as hard as men, that women are softer, they are not as hard working, they have

other responsibilities at home…but what happens is people make assumptions about women and then they are not fair to them in terms of what they offer them not just in lectures, journals, research, articles, and such but even in opportunities to make money…and also advancement to position of a professor or a leader, director, or something like that." Even when women physicians do succeed in getting into positions of power, Saurabh revealed that, "there's an undue level of pressure placed on a woman to succeed…they have to pass a higher bar, to be placed in the same position of power. You know a strong willed woman is really not dealt with very well by the system as compared to a strong willed guy; somebody who will stick to his guns etc is respected by the system. A woman on the other end of that nature is referred to by the 'B' word [Bitch] and everybody tries to undermine her and it's really unfortunate, but I think there is a clear discrimination against women…some vice-chairman women have mentioned to me that they would not be considered for chairs because they are a woman…I have heard that quite a bit."

Regarding promotions in academic medicine Pinky revealed that she had talked to Asian women that have told her "that when they started out there were times when they should have been promoted and they weren't, mainly because they were female." Lata also noticed "…Men much more often get promoted than women and get promoted to higher positions more quickly than women…I feel like their [men] accomplishments get recognized more often." When it comes to hiring women in management or promoting them to positions of power, Shweta

resonated the opinions of other male faculties like Mahesh, Hemant, and David who felt that "…It's kind of an old boys club [in medicine] so if you are a white Caucasian male it's easier for you than if you are a woman or of color…I mean you can look at our institution, the head of medicine has been a male for years, I don't think there's ever been a female head of medicine. Head of endocrinology, male, head of most of the departments are males…." Similarly, Vaishali remarked that for women of color to reach positions of power in medicine "would depend on their history of accomplishment more than anything else. And it might be harder for women of color to build that. I am trying to think of women in color in pathology, who would be at that rank, and I can't think of many. I can think of women in pathology who are at that rank that would be considered for that type of position but most of them are Caucasian, but at the same time I cannot think of women of color who are at that same rank."

Moreover Aparna a female faculty saw that if a man wielded power, "he's seen as righteous and powerful. If a woman yields power she's seen as cruel and bitchy and someone to be hated." Shaurya like Manoj who is a male faculty agreed and remarked "women physicians [in positions of power] have a harder time than male physicians. I think there's more of a stigma of being a woman, there's a stigma of taking time off to have babies, and a lot of women physicians feel like they need to work twice as hard than their male counterparts to get the same respect. And on the same side if a male physician is abrasive and authoritative, people are kind of more scared of him and they will get more

respect than if the female is the same way and the female will be regarded more as just a bitch. And that's independent of race…."

MOTHERHOOD AND PART-TIME WORK

Finally, motherhood for women physicians, as demonstrated by my findings, exacerbates their discriminatory experiences at the workplace in the worst possible ways at all levels of their medical training and career. Shweta recollected, "…there was one girl who was pregnant when she started internship with us…She had kind of planned it so that her vacation would be right around the time of delivery anyway, but they [faculty and administration] were like, 'why can't you just get induced cause you are so close? That way you won't mess up the call schedule or any of that other stuff.' And for a program to even suggest that would be inappropriate, she was Indian." Priyanka felt that women are "…shamed for having a baby [in residency], you are gonna miss all this rotation, you are gonna put all this burden on the other residents, it's really a very hostile environment to try to have a baby…and everybody will just shame you for wanting to do that [work part-time after having a baby] when you are in residency. It's awful."

Parul who returned as a faculty after her maternity leave recalled, "I felt that there was an expectation that I would come back and make up for the time I was gone on my maternity leave…you need to take extra calls, you need to work extra hard, take on extra projects, and make up for the time you were

gone…people think it's okay for me to do some work even when I am on leave [maternity]." Lata, also a faculty, felt that her women colleagues with children "get scrutinized more when they take time off from work." In fact Harish, a senior male faculty in Dermatology revealed, "And what I see is that many of them [women faulty] are moms, so if they miss a few things, then instead of giving them support saying that they are doing things that a man doesn't have to do like take care of their daughter etc, so what they do is they penalize them for that, by not giving them certain rank advancements or pay and things like that…we only have now two women left on all of our faculty… which is bad, and I think one of the reasons people left is because the university really requires people to publish and to lecture and become national and international leaders but these are all women in their thirties and these are very important years as a mom. And so if the university is asking them to do the most aggressive advancement of their career during the times their children need them the most, it's a conflict."

Despite the pervasive reservations and discouragement against motherhood in the medical environment, mothers who actually decide to work part-time as faculties bear the brunt of additional wage penalty and regression in their chances of promotions at the workplace. For example, Uma shared, "I definitely feel like I have to work more [because of being a female]…I took of a few months when I had my children, and I am part-time now, then I was full time. And my chair who is a female, she said that you know if you wanna get promotion or if you wanna apply for promotion you probably gonna have to wait

until you are back to full time because this is gonna look negatively upon you. And I find that odd just because you are working part time, I don't see why that makes any difference…the amount of things that I have done, educational programs that I have done, I think that should play more of a role, in what people think of me as opposed to whether I am full time or part time, so that bothers me…because I took time off you are not eligible for certain incentives, or other things, and that bothered me…that's not ever written down, that's all these unwritten rules…."

However, three male respondents that could be classified as 'outliers' in this study brought up different yet interesting perspectives when queried about the existence of gender discrimination in medicine. Shyam, a gastroenterology fellow felt that unlike in the past, men "have it harder now," and if there are women in power, they "treat the female physicians that are in training more preferentially than the males, almost to make up for the previous discrimination". He felt that there has been a "switch of a pendulum from discrimination to almost reverse discrimination," with much more "positive reinforcement" for women, unlike men in training programs. Besides, Simon, a neurology fellow felt that some women in training often resort to flirting with him and resort to unwelcome advances so he as a fellow could put in a better word for them with the attendings and increase their chances of obtaining a higher grade. Also, Sudhir who is a faculty in psychiatry felt that there has been a reverse trend in his department of "maintaining women in the administration without allowing men

in…like right now there are absolutely no men in our administration…it's just more like an exclusivity thing, where they keep hiring more women, almost like men are getting phased out." And whenever there are any disagreements among faculties in his department, it's usually portrayed as a case of gender discrimination, even when it is not. Although the above findings could signify an actual reversing of trends in American medicine, with reverse discrimination of men by women physicians, these views nevertheless represent only a negligible minority of male physicians in my research sample, contrary to the prevalent opinion of the majority of the physicians interviewed. This however would be an interesting subject requiring further investigation.

THE INTERLINKED IMPACT OF RACE AND GENDER

Despite little being known about how racial and ethnic discrimination impacts the career satisfaction and academic success of FMG women immigrants in the United States, recruiting and retaining FMG faculty in academic medicine remains important. Gender when combined with race acts as a 'double hit' for Indian women physicians who shoulder a double minority status at the workplace: gender and ethnic background akin to Mexican-American women as shown by Melville (1980). Two-third of the women respondents in this study felt discriminated because of their race/ethnicity at their place of work at some time point during their career. An overwhelming proportion (90%) of these respondents reported negative influence of race/ethnicity in positions of power while 1/3rd reported "absolute" or "definite" bias in positions of power based upon

race/ethnicity. And the addition to this of the foreign medical graduate bias (ECFMG) in American medicine cumulates into a 'triple bind' for first-generation Indian women physicians, as was demonstrated by my findings.

When it comes to residency training, Ameena explained how in her program (internal medicine) "the people who are selected as being chief residents, for example from my class we have three chief residents selected from my class, they are all men. Two of them are white and one of them is Indian. And if you go back the last five or ten years, there's very few non-white women or even non-white people, selected residents. Yet the demographics of the residency class, is not white men. White men are actually the minority…people [other students] have said, 'you know it's funny that our chiefs are always white guys when most of the residents are not white guys.'" Harish acquiesces to a similar pattern of selection of chief residents over the years.

The workplace environment of Indian women fellows and faculties resonated similar biases when it came to their hiring, salary structure and social incorporation at the workplace. Deepti, a first-generation woman that joined as a faculty felt that "you are not as easily accepted by your colleagues, your peers to begin with [even as a new faculty]. You have to just prove your worth" Likewise, Gita felt that although no one directly told her anything, she "sensed the racial discrimination" from her colleagues who stopped inviting her "for the social get togethers" even though she was close to them professionally. Pooja however felt

discriminated most when it came to her salary, “It’s soft [racism], it’s not blatant or overt…my first job, I was offered an initial salary, I don’t know that the initial offer would have been higher if I were a man or a non-Indian…but I have some reason to believe that maybe there could be a difference.” While, Shyam’s wife, also a physician felt that the “reason to hire her is that it makes her more of a commodity because she’s somebody that’s…a minority.” and serves as a face value for her institution. In fact Monica, a second-generation faculty felt that “as a woman, and being a minority you have to make sure that you are extra careful, making sure that you do everything correctly.”

In positions of power, Aparna like Ameena agreed that “I think that’s across the board, male Caucasian, tall, the demographics of certain people who are more likely to look like professional and be more likely to be hired than the others.” Likewise Urvashi who is faculty felt that there is both a racial and gender bias in medicine “…if it’s a female and white male and if you are a second-generation female then I think there is no question. And vice versa, if there is a second-generation male and female, the males still have a…[preference].” Sheila commented, “…One of my attendings [African-American female] in residency told me, ‘you have to wear balls around your neck. You have to think like a man, and you have to act like a man otherwise you can’t survive in academics or anywhere.’…They also give women mostly these administrative jobs, where they are in charge of their resident’s schedule, or fellows’ schedule. It’s kind of

secretarial. I see that as a secretarial job. They think that women are more into detail, kind of more obsessive so they give that."

Similarly Lindsay acknowledged that "if you are a black woman or an Indian woman, if you are diminutive, if you are short and slender, you don't have an imposing physical force, you have the disadvantage of being viewed as someone who would not be in a leadership position and it requires extra effort and artful communication to get people to respect you. It's a harder job to get them to respect you, to listen to you, do what you say...I think it's harder to get people to cooperate with you."

Second-generation Indian women like Lata particularly felt that "sometimes achievements are minimized [from Caucasian and African American colleagues, fellow students, fellow students parent] because there are so many Indian doctors anyway and of course you are gonna be a doctor…there's almost an anger like all you Indian people become doctors and kind of take away the spots of everybody else, cause you spend all your time studying…I had someone say that to me in medical school once." Ironically, it is this 'Indianess', which is viewed unfavorably at the workplace and acts as a barrier in the professional advancements of Indian women. Deepika recollected how during medical school she was constantly reminded by one of her Attending Physicians that she was "…already coming in at a disadvantage because you are a woman in medicine, and you are Indian, and Indian people tend not to talk a lot…he made derogatory

comments towards women saying they should be staying home with the kids, they shouldn't be working, they don't do as well at the workplace…well he told me 'you are not gonna do well in you life and in your career, first of all because women don't do as well as men, and then you have all of these things you need to get over your natural cultural tendencies…of not talking very much and of not being open'…that was very insulting and that kind of took me aback cause he was in a position of power over me, he was grading me…." The significance of medical hierarchy is that its power depends on the individual's judgment of competence and appropriateness, and less on impersonal criteria of merit like university promotions. As a result, individual judgments are more likely to lend themselves to discrimination.

Likewise an Indian colleague of Supriya, told her to get rid of her Indianess. She felt that "there is a tendency for women and especially Indian women to be very deferential. I know I have colleagues who are male who have accomplished a lot less than I have yet are extremely aggressive of what they want. They are not shy of asking, 'I demand to have this kind of salary.'…This is something I feel is a cultural thing that I have been taught by my parents. You don't ask for things. That's showing pride and that's too aggressive, and women shouldn't be doing that…I know I have that and I think that has affected other people's perception of me. And their willingness to think of me as a leader because, 'well, she's too meek, she can't be aggressive'…if I was aggressive maybe I could have gotten more than that…especially Indian women, they feel

like they have a lot more to prove, they don't value as much of what they have accomplished…they don't self promote themselves."

GENDER, RACE, AND GRADUATE STATUS

Besides, compared to their American counterparts including the second-generation Indian women physicians; first-generation women who are also foreign medical graduates are worst hit when it comes to being discriminated by their colleagues, senior faculty and the medical system at large. As my research found, they are also seen as competing with second-generation Indian physicians, who are unaffected by the FMG stigma, rigid visa regulations, and accent discrimination, and who offer more promise to prospective employers. All of the women respondents in this study (100%) felt that there is bias against foreign medical graduates in the United States and a vast majority (70%) of them felt that this bias is unjustified.

When Aarti joined as a faculty, she felt that "…you can sense that you have to jump through the hoops essentially to prove that you can lead the team and be expected to handle the team well in crisis or stress situations just like your counterparts who have been trained here or who speak figuratively speaking, the language that they speak." Ameena, a second-generation resident explained how an accent leads to differential treatment of FMG physicians at the workplace whose assessment of patients is easily dismissed by other colleagues. "…I think that if I say something, I am given more respect more easily, if I don't

speak with an accent. But if I had a thick Indian accent I think then I would have to prove myself more." Besides, foreign graduates like Sheila had to work increasingly hard to gain access into competitive fellowship spots, and she was refused a Gastroenterology fellowship at an ivy league U.S. medical university by her own mentors there just because she was an FMG, even though the chairman wanted to take her in. "Absolutely, because of my race and because I being a woman [I had to work harder at the workplace]. Because it's kind of a general notion that women, they would like to spend time with their families and they are not as hard working and they can't put as many hours as men, so I had to work longer and I had to prove that I am committed. And my race, absolutely, because being a foreign medical graduate, and just the same reason, they all think that we are here for money. So when we get into medicine they don't think that we contribute to the research and we all would like to go back to private practice, make a ton of money. Having said that, 90% of the doctors who are born and bought up here also go into private practice. But, when it comes to the foreign medical graduates, there is much more focus on that. So, I have to prove that no, I am interested in research, I am interested in academics and I am not the run of the mill case. But I always think that if I was born here, I would have had much more career opportunities, and things would be different."

When it came to rank advancement, Nidhi a first-generation female faculty felt that it is very hard for FMG's to get promoted at the workplace. "Foreign medical graduates don't seem to be getting as many promotions or be

recognized for what they are doing…it's very subtle…[I have] been here for several years, and a new U.S. grad comes in and maybe on the track to promotion already versus me that is not on the track to promotion…people coming from U.S. schools probably get recognized by the top level people earlier than foreign grads, that's for sure…it' very hard to get promoted if you are Indian or if you are foreign grad…."

Furthermore, foreign graduates particularly women are often exploited into doing demeaning work by their senior faculty at the workplace. Deepika recollected the case of an Indian FMG colleague who was exploited into doing all the "scut work" for some years by her program director. She recalled, "I have seen an instance where they had male FMG, female FMG, both Indian…and the women get treated differently [worse] than the men,"…worse in terms of being asked to do things that were more secretarial jobs [during medical training] than someone who is training to be a physician. And it was perceived to be okay that they were being asked to do that. And what was interesting to me…it was the women who were of other racial groups than white who were being treated that way. The White women around them were never being asked to do that…this was fellowship and the first year of being on faculty."

Neeraj a first-generation male faculty, who has sponsored the visas of some first-generation Indian women, who were discriminated in their medical programs, yet chose to fight the system elaborated, "Why somebody would lie

about my performance? Or the performance of another woman who was fired because they say she has poor communication skills. Now there is no scale to measure communication skills. If she has good command over English, then I would assume that she has good communication skills. But obviously you cannot argue about it, and that will go in her records. And everywhere she goes, everywhere she applies for a job, that will follow her…these are things that you don't read in newspapers, you cannot tell anybody…One case that I know of, she was OBGYN [Obstetrics and Gynecology] and she was a very bright candidate because she was my student in India. And she got discriminated and got fired. She actually wrote a book on OBGYN before she got into the residency-training program. And she got the position in OBGYN that is very rare for somebody coming from India. But then within a year she was fired. And they said that she is not efficient enough, which I don't agree because I have known her when she was in the first year of her MBBS [medical school degree in India]. Anyway, I sponsored her visa in my lab. She worked in my lab for six months and in the meantime I asked her to look for residency somewhere else, and she did find a residency program."

On another case he revealed, "One of the people who was fired had to leave the country in two weeks. And then they had a provision of hearing, so they put the hearing four weeks later, knowing very well that she is not going to able to attend the hearing. And then I sponsored her visa in my lab, so that she can stay here and fight for it and she did stay, but then they postponed the hearing

again. Because I have talked to her many times, I know that she does not have poor communication skills…but then they just lie and nobody is going to believe her if somebody does not know that person…and think that you are a foreigner and maybe you don't have good communication skills. That is how their careers are being spoilt…."

GENDER DISCRIMINATION BY PATIENTS

63% of the women physicians interviewed for this study, first and second-generation apart, felt discriminated by their patients because of their race/ethnicity. Patients on their part discriminated these physicians on primarily three grounds-race, religion, and gender that also resulted in sexual harassment of these physicians by their patients. Christine who has served as a faculty for thirty years and has held senior administrative positions attributed these incidents to the medical environment that allows different behavior from patients towards physicians, "we allow very different behavior from patients than we would allow from colleagues, for example. Just again because the patients are in a very different place and the patients need care regardless of what their biases are." However Lindsay felt that "it would be nice for there to be room within the system for people to consider the fact that physicians can be abused by their patients…its just hard for a lot of people to behave appropriately within that kind of a complicated inter-personal interaction. And I think it's hard to legislate around that kind of inter-personal interaction."

A number of women physicians in this study felt belittled by their patients because of their gender and regarding the confidence their patients placed in their judgments when compared to that of a male physician. Avni like Jyoti felt that “there is a difference when I tell a family this is what we should do, and when one of my male colleagues tells a family that this is what we should do in terms of the confidence that is instilled.” Similarly Madhuri who is in pediatrics recalled a particularly difficult patient-physician interaction she had had with a patient’s mother, “she would kind of listen maybe a little bit [to a male physician] more, whereas if I needed to make a point, we had to have a yelling match to make a point.”

Moreover, physicians like Avni felt that women physicians particularly were commonly referred to as “honey” and “sweetie” and were not given due respect at the workplace by their patients as compared to their male colleagues. Uma too resonated similar experiences and felt that “ …patients think of you differently because a lot of patients are like, you know they wouldn’t argue with a male physician. But with a female physician, I am bothered when patients call me ‘girlfriend’, or they think of me as their friend as opposed to their physician…I find that kind of degrading because I am not your friend, I am here to tell you what I think is in your best interest.” Jennifer who serves as a faculty in a senior administrative position in academic medicine felt that “sometimes you just really have to be a bitch to be taken seriously [by patients], but then once you are taken seriously, usually they will step back, but no they wanna say ‘hey honey, how are

you?' you know." Harish confessed that women physicians were called by their first names, unlike men physicians who were called by their last names by the patients as well as the medical staff and saw that as not fair. Uma also felt that women physicians unlike men faced added pressure to "look better" to solicit patients. She explained, "You know if you are overweight that would not be acceptable. I think it is okay for men to be like balding and bad breath, and look like that stereotypical doctor, because that's what doctors look like."

Women physicians are also discriminated on religious grounds by their patients. Lindsay Watkins, disclosed, "there is pervasive discrimination on that basis I think. Anybody who says it does not exist is lying." This usually centers on whether the physicians follow Christianity or not as experienced by Shweta and Lata, and whether they are Muslims as revealed by my interview findings. Second-generation Ameena who practices Islam was blatantly discriminated because of her religion by a patient, "Honestly, it's [racism] mostly by white wealthy patients. So I was in one of the university clinics, and I walk in and I am talking to this patient, and the first questions he asked me is 'where are you from and what is your religion?' And I told him I was a Muslim and he said, 'Oh you are one of those,' then I said 'I am afraid Sir I am not sure what you mean by that?' And he said, 'you are one of those Muslim people,' and I said 'yes I am a Muslim, and we believe in god,' and he said 'Ya I know what you believe,' and he said, 'why don't you get out of here and tell the attending to come in,' so I left and I did not come back."

In addition, what was fascinating was how first and second-generation Indian women physicians, both felt discriminated by their patients because of their race and gender. Uma like Geeta shared that when she was on call and with a male resident, " it's not uncommon for the patient to think he is the head doctor and I am the resident…even though he could be younger looking than I am, then I am the one being trained and he is the boss, and if he is Caucasian, especially." Likewise Gitanjali like Saachi felt that the patient would be initially taken aback on seeing her, and "would automatically assume that I was somebody junior, and they would look at a medical student who was white as probably the boss." In other cases patients would refuse to cooperate with physicians like Piya and "would just shut off…thinking that…some white man is going to show up as a doctor." Or patients would sometimes use the physicians different accent as an excuse for not following their recommendations, as in the case of Pooja who recollected how she was trying to tell her patient to do something that they did not really want to do and "they kept insisting they didn't understand my English, but I knew that it wasn't my English, it was they didn't want to do what they were needed to do. So I think that was blatant [racism]."

There were also overt cases of racial discrimination against women physicians by their patients. Padmini remembered "one patient [Caucasian], and it was me and my resident who was also Indian, we went down to admit a patient, and the patient was just saying you know he had gone to war, and that

‘all brown people were horrible, and I am not going to judge you for that, I know you are trying to provide healthcare.’ Just horrible things that were coming out of that man’s mouth, it makes it hard to want to go back in the room…he also made derogatory comments towards women…just that he is surprised that women are allowed to be doctors….” 9/11 in turn made Indian physicians more vulnerable in the process as Urvashi explained, “[Post 9/11] Everybody was sort of suspicious of the fact that you are a foreigner, so the foreign thing became a little bit more…they [patients] basically said that you guys don’t know what you are doing here. You guys are just here to take over our country…so the remarks were directly related to the fact that 9/11 had occurred. So they were kind of angry, the remarks were very angry. Clearly they said to go back to your own country.”

Lastly, the occurrence of sexual harassment of Indian women physicians by their patients emerged as a theme illustrating the collective impacts of race and gender in the discrimination of women physicians of color in American medicine. Shyam recollected “great instances” at the VA hospital during medical school, where women physicians were “not treated, or at least not treated as well in terms of being professional. The patient may just say things like, ‘Hey baby how are you doing?’…There were sexual references or not professional things that were said.” Padmini admitted to having had “patients hit on me, I have had a patient’s family ask me out, and clearly that’s not happening to the guys.” Likewise Avni admitted that patients “will be asking you out to dinner and stuff like that, people asking you to have illicit relations with them, people commenting

on some aspect of your body." Shweta remembered more overt incidents when her patients sexually harassed her. She explained, " …There's definitely men that will come on to women, and I think they think that's more acceptable, like patients that think it's more acceptable to come onto a female physician…I had an old man once…older gentleman, was seeing them in the urgent care clinic, finished taking care of him, he came up and gave me a hug. Sometimes patients do that. That's fine. But then he proceeded to hold me, tried to kiss me and then felt my ass. And I kind of pushed him away and walked out…and my friends, female colleagues have had that happen to them before…I have like evaluated a gentleman for a erectile dysfunction, I was definitely very professional, didn't do anything inappropriate. I leave, come back and they are like, 'Oh whatever you did worked, as somebody who couldn't consummate their marriage. I will just think of you next time I am doing it with my wife.' Or they will be like; 'Oh I have got tickets to a game if you ever wanna go.'…Again not appropriate…somebody [patient] actually came in and planted a kiss [on her lips] on her [another female colleague]."

Similarly, Priyanka, a fellow in psychiatry, recalled the complacent response of the medical administration to complaints by women physicians about incidents of sexual harassment by patients, and patient's safety due to the unsafe units that they were housed for the past two decades. "We had to do a full physical exam…when we would like touch them [patients] or examine them, they would just make rude comments, and sexual comments…One of the rules at the

VA is when you do a physical exam, you have to offer them a rectal exam…which made sense for an internal medicine physician or a GI [Gastroenterologist] physician or any physician who is dealing with the physical health…but as a psychiatrist it was very uncomfortable…and some of them [patients] would say yes and you knew that they weren't interested in the test, they just wanted you to probe them…and they would do that with the females, they would never say yes to the males, never…I do feel like having dark skin like myself…we would sometimes get more comments from the African American males because they find it attractive or whatever… we did [complain to the administration], when we were doing it, it was such a bureaucracy and they were like this is the rule, just deal with it, you went to medical school, you are a doctor… it was just like smiling [patients response] or pretending, say they enjoyed it…several people [patients] died on that unit, and there were two reasons they died, one was that they committed suicide and so it just wasn't a safe unit, it was really old and safety was a problem, and some people just weren't doing their jobs and watching people, and the second reason they died is because some of those people were neglected medically and that's because they were asking us to perform things that we weren't really qualified to do… that's stupid because I haven't done physical medicine for years and even if I felt something abnormal, I might not know, I felt like it was negligence…." However, despite being a second-generation, Supriya felt that complaining in such situations was risky and that "there's always this fear that you might be discriminated…you tend to want to slide by. You want to do the right things. But

you don't want to bring attention to yourself because if you did perhaps someone may not come to your aid because you are not white. If I were in that situation I wouldn't have filed a complaint."

WORK-LIFE BALANCE AND DISCRIMINATION AT HOME

Instead of completely assimilating into the American culture or retaining all of their cultural distinctness, continuities characterized the lives of these first-generation Indian women who continued to 'hold at least two frames of reference: the homeland and the country to which they have migrated' (Bodnar, 1987; Gupta, 1997:573; Spivak, 1989). Moreover, children of first-generation Indians were expected by their parents to respect and uphold their interpretations of Indian culture 'in an attempt to reproduce the dense matrix of relationships in their natal cultures' (Gupta, 1997:580), relationships that were not necessarily gender neutral. My findings reveal that second-generation daughters unlike sons grew up to shoulder additional burdens, of being a model minority by excelling in their professional careers along with matching parental and spousal expectations of being the ideal wives and mothers that their first-generation stay at home mothers represented. This actually had a multiplier effect in shaping the career trajectories of Indian women physicians by amplifying the discrimination they encountered, as they occupied multiple yet hierarchical spaces along the race and gender ladder not only at work, but also at home.

Second-generation Ameena despite being a physician and doing well professionally, felt undervalued in her community, as she was not married yet, which also reflected adversely on her upbringing by her mother. She explained, “I think it’s [Indian] a very sexist culture…I am 32 years old, I am not married… people in my community look down on me. I think that’s a big negative because it’s almost like I have no value without a spouse….And that’s something I deal with fairly often….” Madhuri felt likewise when she shared that for her “the biggest conflict comes being a woman is marriage. I think of all the things I have done in my life, I think the biggest disappointment to my parents is that I am not married….” Even when it came to helping ones parents monetarily, as a daughter Lata felt, “it makes me feel like less, because I am a daughter. If I was a boy I could do more for them and they would accept it from me…some level of rejection in some ways. You are so successful with your life, but they won’t still let you help them.”

Even in their roles as wives, Indian women physicians are burdened differentially in terms of their household responsibilities as compared to their husbands, regardless of being in similar professions with the same work responsibilities. Raghav elaborated, “I can speak to one first-generation Indian female physician that I know who is like my parents age…so her own expectations from herself would be that she should raise kids, take care of the house, cook everyday, do all those sort of homemaker responsibilities. Her husband never did any of them…it’s a hard life, you can just see her daily

schedule and know that was a lot." First-generation Piya like Geeta seconded by recalling how she had to do everything at home as well as at work when her children were growing up, unlike her husband.

Although one might assume that sharing of responsibilities at home may be different with second-generation women who were born and bought up in the United States, the variation in their familial responsibilities is not much when compared to first-generation women. Second-generation Lata elaborated, "even if the man and the woman are of comparable level in medicine, it's still considered the woman's responsibility to more take care of the kids…just the general cultural expectation that it has to be the woman's responsibility to take care of everything with the kids…I have some friends [second-generation women] who went through all of med school, went through residency, got married, had kids and just stopped practicing medicine." Second-generation Supriya admitted how juggling work and home had always been a constant battle and probably one of the biggest areas of frustration for her. "…he [second-generation Indian physician husband] will make comments like, 'Oh my mom always cooked dinner and home-cooked meals.' I don't have time to do that. That's too unrealistic expectation. I think the tension between work and home is there for any Indian, any female...there's a little bit more I guess in Indians, and it's almost like guilt you give to yourself because you feel like I am supposed to be the one who takes care of the kids...and for the Indian guys they are used to the role model of their mothers who stayed at home most of the time and cooked

meals for them and doted on them and their wives don't do that. So they have had to change…I can tell you, most of the Indian men will sit and 'can you bring me water?' can't get up and get it themselves…" In fact second-generation Urvashi who was once married to a first-generation Indian male physician, compromised on her career path by giving up a surgery fellowship offer at an ivy league U.S. medical university because of her husband, while being in an abusive marriage with him for some years since divorce is a big taboo in Indian families.

Motherhood and cultural expectations at home in turn exacerbated the already precarious work-life balance Indian women physicians struggle to maintain. Raghav explained how a number of his Indian women physician friends have felt like "they got pushed in one direction or another." Second-generation Tanuja resonated similar sentiments and is struggling between her full time job in an academic setting and her desire to go part-time to be with her child that is usually discouraged professionally as it may slow down her career trajectory. She shared how all her life her parents kept pushing her in terms of her academic achievements "…and the day I got into residency my mom said, 'ok, now you need to get married.' I thought to myself later, I was like 'but you never told me that was important.' All I know is to keep going and keep going, when is it okay to say I am satisfied with what I have? Or when is it okay to say well family is really the ultimate goal? Because in their eyes family is really the ultimate goal

but they keep pushing the academics and forget to tell you that…I feel like I still struggle with what is the right balance."

DISCUSSION AND CONCLUSION

My findings demonstrate that if women physicians in leadership roles act as agents and are authoritative at the workplace, they elicit hostility and resistance from others (Eagly and Karau, 2002; Heilman, et al., 1995; Rudman and Kilianski, 2000). This was apparent as Jennifer a senior faculty in administration revealed that "if a woman is really strong, then people are kind of angry and bitter about that, but if a man is really strong, then he is viewed as a strong leader…I think that sort of perception that a woman is a man-hater or they use that phrase ball-buster." These adverse reactions augment the challenges that women in managerial positions face and also nurture the glass ceiling's they encounter (Ridgeway and Correll, 2004). In fact my research findings confirm that the glass ceiling for women physicians in American academia still persists, with a majority of the study respondents, across gender, feeling that women "can get to a certain height and then you are not gonna get promoted above that point…I think no matter how good you are, even if you look at the medical school administration, there are not many women that high up…."

Although women physicians in my sample reported experiencing discrimination because of their gender at all stages of their medical career, right from residency to competing for management positions as a faculty; motherhood

and the wage penalty it brought with part-time work intensified their disadvantages in every stage at the workplace. This was evident when Uma a part-time faculty, shared how it was “no secret that when you work part-time you are basically doing almost a full time amount of work in less days, so basically all my benefits are fifty percent.” Moreover, status-based discrimination by employer’s stereotypes mothers as ‘less competent and committed to paid work than non-mothers.’ This was apparent when Lindsay a senior faculty in administration, revealed how women physicians who “get on the mommy track,” “loose years of recruitment of seniority or on your promotion track….” It is this implicit bias against mothers that directly impacts and relates to their performance at work by contradicting workplace expectations of ‘the ideal worker’. Piya was discriminated by age and gender along with her race in residency and job interviews. Piya felt that she had to always work harder at the workplace because of her age, “so if somebody did like two calls I had to do three. I always have had to have a little bit more than the other person to say that at least I am equal to you.”

Gender is a basis of discrimination against women physicians also because of the sexist and patriarchal attitudes that are rampant in American medicine. My findings confirm that when compared to women, men are less likely to encourage or steer women to follow a surgical career path (Dresler, et al., 1996), thus contributing to the gendering of jobs. In fact Raghav who is a faculty member in Geriatrics admitted himself that they “do occasionally hear about older

physicians who may have differing expectations of male and female students or maybe biased in their evaluations of students and those sorts of things, based on gender." My research also shows that women trainees and students in medicine are sexually harassed, mistreated and discriminated by gender more often than men (Frank, et al., 1998; Schiffman and Frank, 1995). This was obvious when Arjun, a male faculty member recollected "great instances" at the VA [Veterans Affairs Medical Center] hospital during medical school, where there were a "lot of times if you are a female, at the VA, you can be sexually harassed by the patients there." Likewise, women physicians in leadership roles at medical schools, encounter more hostility, gender discrimination, and sexual harassment than men

Also, 'when the physician is female and the patient a male, the male patient may become flirtatious out of anxiety about the reversal of the power situation and attempt to reverse it by asserting himself as a sexual male' In my research sample, although discriminatory attitudes against women physicians did resonate in all of their interactions with their colleagues, attendings, and their nursing staff as well, it was the professional interaction of women physicians with their patients that reeked blatantly of these sexist and patriarchal attitudes. Shiva a senior faculty in administration who was interviewed for this study did not appear very encouraging of female physicians lodging complaints and taking actions against patients who sexually harassed them. He argued that there was usually a pattern of sexual harassment by a patient, who would act the same with

other female physicians as well. And if one woman physician kept complaining, the system would think that something was wrong with her and would tell her to press charges only if its worth all the time and the legal hassle that will go into it. Women of color are more severely sexually harassed through a 'racialized form of sexual harassment,' as was evident by Priyanka's experiences in my research findings, who felt that she got more comments from her patients because of her "dark skin".

However research shows that female ethnic minorities in American medicine may have difficulty in determining if it's their race or gender that gives rise to 'offensive, harassing, or discriminating behavior.' My findings demonstrate that women physicians from ethnic minorities may achieve social mobility and gain economic parity in the United States, but only as exceptions to the rule, as evident by their perception of the gender and racial discrimination in promotions, referral patterns, and the "glass ceiling" faced by them "when it comes to really rising to the top." Besides, combating institutionalized discrimination and discriminators who act with institutional backing can be mentally taxing and financially draining for individual physicians. As illustrated by Neeraj who shared a case of a second-generation Indian female physician who did win a gender discrimination lawsuit for 1.6 million dollars against a prestigious university hospital in Massachusetts, but "after that judge went, they fired her chair and then they [university] appealed that their [judge's] judgment is wrong…and it is

going to go on for a couple of years. And they [university] have a lot of money. They [lawsuits] cost a lot of money."

In comparing experiences of second-generation versus first-generation physicians, interesting differences as well as similarities were observed. Due to relatively small sample size, statistical analyses to test for significance were not performed. More second-generation physicians felt discriminated because of their race/ethnicity (71% versus 50%), believe that there is gender-based discrimination against women in positions in power (88% versus 60%), and that women physicians have to overcome extra hurdles at work (85% versus 61%). However a greater proportion of first-generation physicians (50% versus 35%) reported that they had to work harder or prove themselves more at work because of their race/ethnicity. Although all first and second-generation physicians reported that there is foreign medical graduate bias in the U.S. medical system, fewer second- versus first-generation physicians felt that it was unjustified (10% versus 45%). Similarly, while similar proportion of both first (90%) and second-generation (87%) physicians reported negative influence of race/ethnicity in positions of power, more first-generation physicians reported being discriminated by patient because of ethnicity (65% versus 57%).

Moreover, the professional and personal lives of Indian women physicians in the United States, first and second-generation likewise, continue to be shaped and constructed through power relations rooted within the traditional Indian norms that they are required to uphold even though they work at par with their

spouses at the workplace. In addition to being discriminated at the organizational level, a majority of the Indian women physicians in this research were also discriminated at home in their efforts to maintain a work-life balance within their roles as daughters, wives and mothers. But for the first-generation women as my findings demonstrate, the transition to America “just happened as a matter of course” and their work-life struggles at home were more internalized and less recognized by even them as problematic or discriminatory. They had to be equally efficient at work, as they would be expected at home in the United States, which would still be run like traditional households in India with unequal sharing of responsibilities between the spouses, with women usually shouldering the greater burden. They were socially conditioned by their families in India to never question their added responsibilities and take them as a part and parcel of married life and of being a good and chaste Indian wife and mother. Rebelling, or questioning their added burdens would prove them to be otherwise and would not be a good reflection on their upbringing or on their parents. While the second-generation women that grew up in the United States, after having observed the chasm between patriarchal Indian practices at home and the far more liberal and empowering American lifestyle outside were far more conscious, articulate, and comparatively proactive about their dilemmas and struggles of blending home with work.

This study of gender discrimination reveals how gender and race are intertwined and deeply embedded within the informal organization of U.S.

medicine, configuring the daily interactions of women physicians of color. In particular, the stigma of being a foreign medical graduate in addition to their gender and race multiplies the discriminatory experiences of first-generation Indian women physicians. Thus regarding the conditions of new racially different immigrant groups, the interconnected complexity of gender and racial inequalities requires further analysis. My research shows that even high-skilled immigrants of color and their second-generation counterparts need to build their identities against the backdrop of gender and racial hierarchies that remain pervasive and regulate their social mobility and occupational structuring in the United States. Focusing on either one category will ignore the internal divisions of races along gender lines, and preclude an understanding of how the two categories have a complex, mutually reinforcing or contradicting interaction. Recognizing how cultural biases about gender, race and sexuality color their interactions will constitute the first step towards understanding their experiences in the medical arena.

Chapter 5

SEPARATE WARDROBES AND CONTESTED CITIZENSHIPS

SOCIAL INCORPORATION OF INDIAN PHYSICIANS IN THE UNITED STATES

"I feel people like us [laughs]… we are actually torn. I think it's easier for my daughter not to feel that way. But at least for people like us, ideally if you had a group I did still be first-generation not only because I was born in India, bought up here. But still having lived that long, it's a conflict that I feel within myself. Because you feel like you neither belong here nor there. So when you go to India you are not like them, when you are here you are not like them. So who are you? ...You almost fall into this snapshot, whenever your parents immigrated, you live in that age forever almost…but if you were to ask what is the country, I would say I don't know. And in fact some days sometimes you feel really hollow because you don't know where you would be accepted the most, or who you really are…This is a conflict that resides in us that I don't know how its going to be resolved, and you can just wait for the next day to tell you what's gonna happen. We kind of live from day to day.**"**

Smriti Irani [1.5 generation], In-depth interview, U.S. Southwest, July 2009[9]

Racial problems in the United States in fact have at times been equated

[9] Name changed to protect the privacy of the respondent.

with problems of assimilation (Park, 1914). Robert Park (1914) argued that the primary goal behind promoting like mindedness and homogeneity in cosmopolitan countries was to replace racial with personal competition that would encourage individuals to seek and attain positions they were most capable of irrespective of their race or social status. Assimilation as Park and Burgess (1969:735) defined in 1921 was ‘a process of interpenetration and fusion in which persons and groups acquire the memories, sentiments, and attitudes of other persons and groups and, by sharing their experience and history, are incorporated with them in a common cultural life.’ The restricted notion of assimilation envisaged by Park and the potential problems inhibiting social assimilation that he ruled out was evident in his later definition that described social assimilation as ‘the name given to the process or processes by which peoples of diverse racial origins and different cultural heritages, occupying a common territory, achieve a cultural solidarity sufficient at least to sustain a national existence’ (Park, 1930:281). As a result, Park has been critiqued by many later researchers (Alba and Nee, 1997; Lyman, 1973; Stone, 1985) for foreseeing ‘assimilation’ as an unavoidable outcome of “contact, competition, accommodation, and eventual assimilation,” that categorized his “race-relations cycle” (Park, 1950:138).

Milton Gordon's multidimensional conception of assimilation into the American life (Gordon, 1964; Gordon, 1961) provided a methodical bifurcation of assimilation into multiple sub-processes that characterized it, by his seven

stages. However it was the distinction between ‘behavioral assimilation’ or ‘acculturation’ and ‘structural assimilation’ that constituted the most central distinction in his conceptualization. Acculturation for Gordon led to the adoption of the cultural behavioral patterns of the receiving society by the minority groups. While widespread and intensive structural assimilation of immigrants and their offspring’s into the institutional activities, organizational life, and social cliques of the host society would be followed by a ‘high frequency of intermarriage’ and decline in discrimination and prejudice as a result (Gordon, 1961:279). By this reasoning one would assume that increased intergroup marriage would actually herald the social incorporation of immigrants and their descendants into the organizational and institutional life of the host society to a large extent, which may not actually be true.

Moreover it is not clear if Gordon intended to apply his hypothesis to groups or individuals, conceiving of assimilation ‘within a two-group framework of analysis’ thus seeming less reflective of the diverse ethnic composition, inter-mixing and its larger implications for the American social processes (Alba and Nee, 1997:830). His theorization of identification assimilation, as the ‘development of [a] sense of peoplehood based exclusively on [the] host society (Gordon, 1964:71) appears to be problematic by overlooking how an ‘overwhelming majority of Americans still acknowledge some non-American ethnic ancestry’ (Alba and Nee, 1997:831; Lieberson, 1985; Lieberson and Waters, 1993). It also disregards how the daily lives of new immigrant groups and even their second-generation descendants today is contingent on the

‘multiple and constant interconnections across international borders’ and their ‘public identities are configured in relationship to more than one nation-state’ (Schiller, et al., 1995:48). Occupational mobility and achievements of ethnic minorities in the attainment of scarce goods such as advanced training and positions of power vis-à-vis the natives is a critical indicator of their socioeconomic assimilation (Neidert and Farley, 1985), which is also left unaddressed by Gordon.

The segmented assimilation theory formulated by Alejandro Portes and others (Portes, et al., 2005; Portes and Rumbaut, 2001; Portes and Zhou, 1993; Waters, et al., 2010) appeared in the 1990’s as an alternative to the earlier theorizations on assimilation. Portes and Zhou (1993) argue that the process of assimilation and its expected consequences for the new second-generation has not reversed completely, but has become more segmented now. They envisage three alternative paths that the second-generation are likely to adopt in course of assimilating socially and economically into the American mainstream. ‘One of them replicates the time-honored portrayal of growing acculturation and parallel integration into the white middle-class; a second leads straight in the opposite direction to permanent poverty and assimilation into the underclass; still a third associates rapid economic advancement with deliberate preservation of the immigrant community's values and tight solidarity’ (Portes and Zhou, 1993:82). Portes and Zhou (1993) illustrate this third route by giving the example of Punjabi Sikhs in California who were able to achieve substantial economic advancement

by offsetting the pervasive discrimination that they faced from their white counterparts, despite any assistance from the government or support from other co-ethnic groups. They argue that the controlled and selective assimilation practiced by the Sikh community, with the immigrant parents playing a decisive role in shaping the outlook of their second-generation children and their approach in combating white prejudice actually proved to be the ideal route for these ethnic minorities (Portes and Zhou, 1993).

Alba and Nee instead define assimilation as 'the decline of an ethnic distinction and its corollary cultural and social differences,' with decline signifying how 'a distinction attenuates in salience, that the occurrences for which it is relevant diminish in number and contract to fewer and fewer domains of social life' (Alba and Nee, 2003:11). Employing a new perspective of institutionalism to understand assimilation they argue that incorporation of immigrants is 'something that frequently happens to people while they are making other plans' (Alba and Nee, 2003:282). Socio-structural assimilation is actually an indirect consequence of immigrant's entry into the economic and occupational mainstream, as they strive to attain equality in their life chances akin to the native population. But their extent of assimilation is predetermined by the institutional framework, occupational opportunities, and regulations of the state within which immigrant's function. However, Alba and Nee (2003) argue that human capital immigrants are able to assimilate socially and economically into the host society within a moderately small period of time, with their second-generation children often

complementing and occasionally exceeding the achievements of their native American counterparts. Assimilation today is a bilateral change for Alba and Nee on both sides of the ethnic boundaries. It is facilitated by the institutional reform following the federal regulations that outlawed racial discrimination and promoted equal opportunities in employment, resulting in greater socio-economic mobility of racial and ethnic groups that had been excluded earlier from the American mainstream. Hence they conclude that the social and economic origins of ethnic minorities, in particular the second-generation are less decisive in predicting their socioeconomic integration or curtailing their upward mobility in the American mainstream (Alba and Nee, 2003; Waters, et al., 2010). However research shows that earning differentials still persist across ethnic groups even after controlling for other factors like level of education, region, and occupation (Kim and Sakamoto, 2010). Tuan (1999) shows how only those third-generation respondents who have spent extended time in their motherland or have an immigrant parent, actually feel at ease in identifying with the foreign-born. Most of the other respondents see themselves as undoubtedly being related but different from Asian immigrants. It is as a compromise to honor their ethnic as well as American roots that they choose to adopt a hyphenated identity (Tuan, 1999).

To explore my interviewee's perception of the nature of racial discrimination outside of the workplace I focus on schools, neighborhoods, and public places as possible vehicles of discrimination. I also investigate the tensions dictating the relationships of first and second-generation Indians, in

order to understand the internal conflicts experienced by both the groups and how this hinders their assimilation into the American society. The sections, which follow, address the findings of the two major issues impacting their incorporation in the United Sates that emerged in my interviews.

NAVIGATING THE PUBLIC PLACE

Shashi categorized her childhood racial interactions as “equal hatred to everybody.” While Smriti, Shalini, and Jayant recollected being teased by other children for being different, whether it was in their accent, their dress or the way they looked. Sadia, a second-generation Muslim of Indian origin felt discriminated by her classmates and teachers alike because of both her religion and race. She recalled how during school she “was made to feel that white people were more beautiful, white people were smart, white people were more athletic than any other kind of people. I was told when I was growing up, that the only interesting history was European history.” Deepika also recollected how “no one in the cheer leading squad was brown even when there were more brown people in the school…[who] never got picked.” Likewise first-generation Sana recollected having heard “snide remarks” and facing “preconceived notions” by her technician and other people in graduate school, although she “made an effort to blend in as opposed to stand out.”

However my findings show that the nature of discriminatory experiences differs substantially between genders and racism is often very pronounced and

overt among second-generation boys where it can often take the shape of name-calling and physical bullying. In fact first-generation Ridhima and Suhana both admitted to being concerned about their school going children in the United States particularly after having heard and seen that “in the elementary school, all the kids of all races, like they are all friends. But by the time they come to the middle school, they kind of form groups according to their race and skin color.” Ridhima elaborated, “the kids are really cruel and they are mean. They try to get physical too and they use the race as their catch point, to intimidate them.” Second-generation Atif recalled how racial discrimination by other children during his childhood created an “awareness of racism as a potential entity” for him. Sudeep recalled how there was “a definite discrimination against anybody who was a darker color” other than students who were of European descent during junior high. In fact a majority of the second-generation Indian men like Saroj, Arjun, Abhijeet, Shyam, Harvinder, Inder, and Omi recollected being “picked on” and “made fun of” and referred to as “nigger,” “sand nigger,” “rag head,” and “camel jockey” by other children in elementary school, high school, and middle school. Puneet who was threatened to be beaten up by other Caucasian, and African American children in fourth grade argued, “when you are young you don’t realize the color of your skin, you don’t realize who you really are, you play with everybody but as you get older then you start realizing ‘oh ya, I am Indian, oh ya, I am different than other non-Indian kids.’…The way I dressed, my body language, the way I walked, everything was very insecure, and I was very introverted and quiet. So those experiences, growing up in high school, I hated

high school. High school here was very difficult for me…probably traumatic for me…I would come home at the end of every day crying for the first few years, just because I didn't feel like I fit in. I knew I was different, I knew I wanted to be more popular, everything that kind of goes along with that age group of people. But also I was in gym classes especially, I can tell you I was definitely picked on. Several instances the guys stole my pants, they stole my wallet…there is always this threat of being beat up after school for elementary school kids by bullies. I was definitely bullied growing up. And so I remember walking home from school and there's a kind of group of kids that were threatening to beat me up and they kind of pushed me around, and tossed my bag around, took everything and I think they dumped it out of my bag…they never hurt me physically at least, but emotionally they probably did…high school that kind of almost repeated itself…they [bullies] were African American…it was more the mental trauma of somebody threatening to beat me up [than the actual physical act]…Looking back on it…I was actually lower on the toll poll if you will with regards to respect and so they felt that they could disrespect me."

Their residential experiences in neighborhoods resonated similar discriminatory patterns. Deepika who belonged to the only non-White family in the bloc revealed, "we had eggs thrown at our house…quite a few times…but it didn't happen to anyone else, anyone in our neighborhood except us" Likewise Vikas shared how a lot of children that he went to school with and played with "would make fun of me because of the color of my skin, sometimes if they saw

the dress that my parents wore things like that. In the neighborhood where I lived we have had several instances where there was graffiti on the garage door, or cars were tampered with by the kids in a way to suggest that you know they were making fun of our background…I was subjected to a lot of ridicule by other kids as a child growing up." Even on the streets, gas station and in grocery stores they were shouted at by other Caucasian men who told them to "go back to where you came from," "you afghans go home," and "if you ain't white, you ain't right," and were asked by other African American men who had a shotgun, "you ain't white, and you ain't black, what is you folks?"

Discrimination of second-generation women on account of religious differences also emerged as an important factor in their experiences. Vaishali recalled having felt "isolated by religion" as a child. Whereas Reeta and Monica remembered comments geared towards religious implications such as if they were not a Christian they were going to "rot in hell". Anu in fact revealed how her friends would try to convert her and people did not want to date her because she was racially and religiously different than them. Puneet had a similar experience in adolescence where he perceived that a "white girl would never be attracted to an Indian guy, they are only attracted to white guys," which "played out to be true for the most part as well [laughs]" for him. With food being an important component of the Hindu religion, a number of second-generation Indian physicians were vegetarians for religious reasons. And when queried about discrimination at the workplace, they brought up the frequent absence of

vegetarian food options at work as Inder explained, “at our lunch meetings there was never vegetarian food…but that was one of the things that maybe people didn’t understand about being Indian.”

Even regarding law enforcement Deepika recollected how her sister often “got pulled over a lot for no reason at all, and when she had her white friends in the car, she didn’t get pulled over.” Likewise Khushi, Aryaan and Mohan “felt somewhat profiled against,” and “degraded” particularly Aryaan who was pulled over by a cop while driving, and the first thing that he was asked was if he stole the vehicle. Similarly, in fast food chains, stores, and car dealerships discriminatory experiences shared by Preeti, Deepesh, Mohan, and Smriti ranged from either outright discrimination where they were told that “we don’t serve your kind here” or to more subtle discrimination where they could “sense that they are more interested in the white customer” or an African American in line. Similar discriminatory experiences were reported by first-generation Padamja, Saaras, Jiya, Goel, Pahal and Savita who found Caucasian shop and hotel owners to be “sullen, irritated” for being bothered by them or not providing “much customer service.”

Deepika feared that she thought, “Being in America and being any color, there are always bad things associated with that. Because there are situations that I am gonna go into, I know that people are going to look at the color of my skin and just because of the color of my skin are going to have preconceived

notions about me." Second-generation Harvinder argued that what the Americans did to the native Indian Americans, "although it's never written in the textbooks like that, what we did to that group of people was genocide. Now that may be a very radical [statement], and I bet no white American would ever equate what was done to native Indians as genocide but it was, it was genocide. And it was systematic elimination of a race. That will never be viewed like that…what we did with slavery was wrong. Those types of things should never be repeated. And hopefully we as a country have learnt from those. I am not sure if we have." He felt that U.S. political stances on various social issues still resonated the "colonial, imperialistic concept" that was now "couched in a different term." Similarly second-generation Dravid felt that "people still have the hatred and the discrimination and all that inside, but they just don't talk about it now. I think its still there. White people still think that it's their country and they sort of act like that. And treat other people that are not white as if they don't belong sometimes…in the community you will see things happen." Similar viewpoints were espoused by some of the first-generation respondents in the study. Kirpal argued "there is always discrimination...if you go to a party, other people may not open up to you or they may not come and talk to you, because they don't know who I am and why I have my turban." While Saagar felt that whenever there was an economic downturn in the United States, people were not happy with the fact that "you as someone who immigrated to this country ten or twenty years back is doing better compared to someone who has been here for generations."

However first-generation Charak thought otherwise. He argued, “I think in India the minute you start a conversation, people want to figure out which caste you are from, which language you speak, where your parents came from, so at the social level you get categorized and often times not fully accepted if you are not in the right group for that person who is talking to you. And it may have been that the color of my skin which is kind of quite fair, and my language abilities which are poor in the local languages [in India], the fact that I am a Christian, and all of these may have gone into it, but I had more of taunts and things thrown at me in India than here [U.S.].”

Moreover quite a few second-generation women like Smriti, Shashi, Prerna, Aarti, Saroj, and Anandi felt that being an American allowed them to “continue to be an Indian but with more opportunities.” They were “less held back here” and had much more independence and freedom to express themselves professionally, and to realize their career goals. And they feared that if they had been in India they would have been ‘stay at home’ mothers, given the “subservient” role of women in India and their responsibility to share the larger burden of taking care of the family and children. Interestingly, none of the first-generation women physicians shared similar perspectives. This could partly be attributed to the fact that the second-generation women grew up in the United States with their first-generation mothers, who had experienced a different India in terms of empowerment of women, where women were more rooted at home

and they shared this version with their daughters. However contemporary India has changed a lot in terms of women who take up a professional career, yet blend home and work successfully, and have the convenience of readily available domestic help and family support in India, as my first-generation respondents, men and women alike pointed out.

SEPARATE WARDROBES AND CONTESTED CITIZENSHIPS

Social incorporation of physicians of Indian origin into the American mainstream retains its contested character due to the identity conflicts they experience in having to blend Indian with American values. These conflicts are however experienced differently by men and women, and by first-generation Indians as against their second-generation counterparts.

First-generation Gauri who struggles to blend her Indian and American identities together explained how, “the first area that gets affected is the way you dress, from the traditional clothes to the western clothes and even in the western clothes going from relatively conservative to the point that you are blending in the mainstream”. Likewise Saachi who had worked globally and used to dress in traditional Indian clothes before immigrating to the United States, explained, “I had to change, very deliberately when I came to New York only because the secretary told me that it will be better, ‘you speak fluent English, and you are conversationally fluent, but if you wear that salwar kameez [Indian attire] people may not look upon you as efficient’…it was extremely hard to make that

transition." Moreover Pamela like Aarti felt that traditional Indian ways of managing home proved very difficult along with an intense career in medicine, "at home we do things very similarly as we used to do back home in India, and you come back to work and you do [things American]…for me its very tough." Interestingly Ridhima did not feel the need to assimilate into the American culture, as she felt proud of her culture, and did not want to be the best of both worlds.

For first-generation Indian men like Mangal, finding a balance between being Indian and American was sometimes "difficult". Atif experienced a "steep transition" in adjusting to the American culture inside and outside of the work place. Similarly Dravid explained how he had been to many baseball games but he did not like going to these games. "You go there just for the atmosphere, hanging out with friends. So those are like sometimes you feel yes you are different from all these people." Charan in fact explained how the cultural differences between the two countries did limit him from fully immersing himself into the American culture, "…we used to have a lot of dinners in India and we used to have lots of dinners in U.S. So if I go to a dinner in U.S. and if I go to a bar and there is music and there is a big television with sports going on. And we have a very similar thing in India. I go out and I just take a beer and there is music going on. So the music in U.S. is a totally different music, I don't enjoy that music, I want to listen to Indian music, right. Second, the games here are totally different. They will look at the television; they are playing some different games,

which I don't understand, so for me I don't enjoy that party. And similarly if I go to a dinner with my departmental friends, most of the time I don't relish the food over there, because it's not to my liking. Most of the time I go to places where most of them are eating non-vegetarian, beef and other stuff, which I don't like, so the dinner also becomes basically a waste of time. Though I don't say it's bad, but there are cultural differences and I don't want to change myself to that extent."

A majority of the second-generation respondents reported to have experienced conflicts within themselves in having to blend their Indian and American identities during their childhood and even now as adults in the United States. While Nakul differentiated being at home and school or the workplace as "two separate worlds", for Tripathi it was more of being "stuck in the middle." Smriti explained how she felt "lucky", as she was both an Indian and an American, "but in another way it's heartbreaking because you are neither. So when you go to India, you are neither Indian, as they treat you differently. I feel like a foreigner there. And when you are here, you are American, but you are really not accepted as American, because you feel like a foreigner here. So you have no place. You are sort of a land by yourself, but you hope that other people feel sorry about this. I am sure as long as we look Indian, and you don't look like everybody else, you are always gonna feel that, no matter how long you have been here…Even though you are American, you are American in the sense of function, but you are not American in the sense of mentality. Your outlook is

different because we still have that cultural bias in our head…we actually have wardrobes of two types, when I go to an Indian function then I wear Indian clothes, when I go to an American function then I wear American clothes. Separate wardrobes for different occasions." Likewise Dolly argued, "when I go to Indian functions, I am always a little bit conscious especially because of the label of ABCD's [American Born Confused Desi] about how I am being perceived. I don't think I know the language as well. I don't think I blend in as well because…I am not as familiar with the jokes, and the plays, and those sorts of things. So that always creates a little bit of this internal conflict…sometimes when I am with my American friends, I feel like 'ah this is all different than what I am.' Often you don't feel like you fit in either place totally."

Similar conflicts resonated in the experiences of a number of second-generation Indian women like Arpita, Jayant, Deepika and others. In fact Vaishali laughed a lot when I asked her if she had ever experienced conflicts within herself in having to blend the two identities together. She elaborated, "Of course at home when you are with your parents, you are automatically Indian, because that is what you are expected to be. And at work, you automatically become American, because that's what you are expected to be. You end up acting the way you are expected. For a second-generation person you are always a chameleon, you always change, based on what's expected of you and in which situation you are in…I want to be whatever makes the people around me feel comfortable. And so I change myself, in every situation that I am in, based on

whom I am with. The problem lies once you leave your parents zone, and then you have to decide, whom you are going to hang out with and how am I going to act, now that I am completely alone and there is no one who is expecting anything from me…what do I do in my free time…if you think that then you get emotional. And so like some days I will go to the temple because I miss going to the temple with my Dad. And some days I will go out to the movies, or shop or have pizza…" Bhema on the other hand did not experience any conflicts as when he would be at home, he would be "mostly Indian", whereas at the workplace he would be "mostly American".

Moreover for a majority of the second-generation physicians, men and women alike like Reeta, Sanjeev, Omi, Kavya, Sumit, Shalini, Urmila, Saroj and Puneet, growing up in the United States was a constant struggle at home where their parents tried to enforce strict Indian values on them, while they wanted to be more American. Nandita explained how the second-generation of the 1990s grew in " an idealized version of the India that their parents grew up in. The version of India that their parents saw in the movies was overly stylized. Like out of reactionary fears they tried to make their home and their ideals that they taught in their home, a very idealized version of what India was…and they change their memories to be much more conservative and much more stylized than India actually ever was…" Daughters often had it harder than sons, with their parents being much stricter on them.

Dating and marriage for second-generation women was equally problematic, as was the freedom to choose their partners. Sadia like Kavya felt that the Indian community minimized her professional achievements because she wasn't married yet. Referring to the cultural seclusion between northern and southern India that continues among the second-generation Indian community, Preeti while dating other second-generation Indian men, found that some of them were not comfortable with her because of the part of India she was from. Vivian revealed how parents married their second-generation daughters to first-generation Indians in order to preserve their culture. Their daughters often met their prospective husbands in "controlled settings" like bible classes or the temple and dated within that. While for Nupur her parents had set up what she called her own "dating service" where her parents arranged for her to meet second-generation Indian men for marriage. While Saroj like Kavya who was still single was pressured by her parents to get married to a second-generation Indian from her socio-cultural background, and held her parents as responsible for her not having found a suitable partner because they discouraged her against dating until her mid-twenties and then wondered why she wasn't married yet.

Nandita who was often told by her father that "patti devo bhava" or the husband is like god; was skeptical of getting married to an Indian "because if I was marrying Indian, or an Indian American…despite being a doctor, and working full time, I will be expected to do all the responsibilities of a housewife, who is doing nothing but sitting home and cleaning all day. And my house will be

expected to be just as clean, and the meals will be expected to be just as ready, even if I were working forty hours a week or sitting home, there is no slack given, there is no leeway given. You are expected to do two jobs at once, you are expected to do forty hours a week as a housewife, forty hours a week as a doctor. That's how my mom [first-generation physician] was treated… which I think probably is a big part of the reason why I am not married yet." Nandita talked of the dualism in values, also experienced by Saroj, Anu, Deepika and Monica, that was nurtured by Indian parents in their daughters lives where they wanted "their daughters to excel academically so they treated them like sons, and once they get married they are still expected to perform as daughters," and as traditional Indian wives, an expectation also upheld by their second-generation husbands. In fact Nandita did not really get along with many second-generation Indians because her version of what Indian morals were and what it meant to be an Indian American was completely different than many other Indian Americans, a fact experienced by Arpita and Preeti as well who talked of "varying degrees of Indianess" among second-generation Indians in the United States. For Nandita it was "different enough to cause anger and resentment" and "a lot more arguments." She felt that it was a lot easier for her to be with an American as there was "no baseline version of what the right version of being an Indian American is."

Likewise Sumit also mentioned how everyone had a different interpretation of being Indian, because of which he rebelled as a teenager and discarded all of

it. He felt discriminated by people in the Indian community because his “closest friends were all white. Rather than going to an Indian function I would rather go to a football game with my friends. More than one time I was kind of viewed as a traitor to my people, which I thought was completely absurd and actually more ignorant than the people they were accusing me of being with.” Like Sumit, and Sudeep, for Aryaan getting married to a woman of another race was one of the most difficult experiences to bring up with his parents who felt he would be renouncing all of his Indian values and traditions. Sudeep reminisced, “especially when I became a teenager and adolescent, I wanted to be like any other American boy and date girls, and get to know girls, and fall in love. It’s amazing that every Indian movie is about falling in love, but every Indian parent never wants you to do that. They want you to get arranged marriages. So that just maybe reflects a deep desire in every Indian’s heart to fall in love. So I did that. I am in a love marriage. So I had a lot of conflicts based on the Indian traditions that my parents wanted me to follow and the American way that I grew up which said that you need to follow your own path to a life long mate.”

DISCUSSION AND CONCLUSION

Past theories of assimilation reflect a limited spotlight on race, with respect to the ethnically diverse composition of American society today and particularly by regarding the social incorporation of high-skilled immigrants and their second-generation descendants as gradual and inevitable. However immigrants forge their identities and life chances in relation to their social similarities and

dissimilarities with people around them, in particular the reference group (Rumbaut, 1994). Moreover for second-generation descendants of color, growing up in the United States remains a conflicting experience, as they oscillate between cultural pressures and social confrontations that affect their adaptation process (Portes and Zhou, 1993). In fact my interviews with second-generation Indian physicians, most of whom grew up in predominantly white neighborhoods and white schools, were not reflective of much communal support that they had during childhood, which exposed them to blatant racism by other children of their age on one end and lack of ethnic enclaves on the other.

In a recent study Brettell and Reed-Danahay (Brettell and Reed-Danahay, 2012) find that immigrants from India become American overtime. Indians fortify their Indian identity through their participation in regional and religious organizations, which celebrate cultural traditions and cultural differences. At the same time, they assert their American identity by using these organizations as mediums for civic engagement (Brettell, 2005). For Indian immigrants, becoming American is markedly different from becoming a U.S. citizen and they report their American identity shifts hinge on different contexts. In their study, 81 percent of fathers who were first-generation Indian immigrants reported to somewhat commonly identifying themselves as American, when compared to only 44 percent of mothers (Brettell and Reed-Danahay, 2012). Moreover, despite wanting to overcome feelings of otherness and assimilate in the United States, Indian immigrants in this study reported to have been excluded by fellow

Americans on the basis of their skin color, their accent, and their ethnic characteristics.

Studies show that race does play a meaningful role in shaping racial identities and orientations of children, in their selection of friends and in determining their prejudices towards others (Aboud, 1977; Ausdale and Feagin, 1996; Clark and Clark, 1939; Schofield and Francis, 1982; Spencer, 1987). My research confirms studies that show how even young children use racially derogatory comments for people with middle-eastern descent on children of Indian origin in the United States. Children also act differently in absence of adults and when they are alone with other children (Danielewicz, et al., 1996). And they 'display prejudice by the time they arrive at school,' 'have constant, well-defined, and negative biases toward racial and ethnic others' and do 'understand that simply by virtue of their skin color, Whites are accorded more power, control, and prestige' (Ausdale and Feagin, 1996; Ramsey, 1987:791).

Omi who immigrated to the United States when he was seven admitted, "so children that time, even now they make fun of you if you speak differently, if you look differently, I mean general if you are not white, or black." Such experiences in schools and neighborhoods further inhibit complete assimilation of second-generation children into the U.S. mainstream. Moreover Ausdale and Feagin (1996) argue that children are likely to repeat such behavior after pre-school in other social settings. My findings also confirm that second-generation children

who travelled back forth for a prolonged period of time between the two countries, had it worse in terms of the discrimination that they faced in India and in the United States. As Puneet who immigrated to India for four years when he was eleven, admitted, “that is actually probably the first time that I felt different within my own skin. Ironically I felt more American and a foreigner in India than I did feel Indian. So that was the first time that I was teased a lot in India. The first few days to weeks were very difficult. The guys would make fun of me, my American accent…I remember crying several times at school. I just was very frustrated….” And the same story coupled with physical bullying repeated itself for him when he turned fifteen and came back to the United States.

Social Incorporation of High-Skilled Professionals

Although second-generation Indians, occasionally regarded as ‘honorary whites,’ do aspire to assimilate and have equal life chances as the dominant group, research shows that ‘they are still keenly aware of their inferior racial status, internalizing the disadvantages associated with it’ (Tuan, 1998b:1149; Zhou, 2004a; Zhou and Xiong, 2005). Monica rediscovered her Indian roots in medical school with other second-generation Indians who made her realize how “growing up everyone pronounced your name, anglicized it” and she assumed “that’s normal because there was no body else to tell me otherwise...I almost feel like I kind of anglicized myself growing up”. Social incorporation and occupational mobility of ethnic minorities remains problematic, despite leveling of socio-economic status and evaporation of cultural and language differences in the

United States. This is because prejudices of dominant groups are based largely on ascribed characteristics like 'skin color, language of origin, and religion' that play a significant role 'in determining the level of acceptance of minorities by the dominant group (Warner and Srole, 1945; Zhou, 1997:976). As second-generation Arjun indicated, should India grow economically and a lot of jobs would be outsourced to India, Americans might become more "spiteful" and have a "negative attitude" of Indians. Low levels of acceptance in turn reflect the increase in social distances and feelings of reservation and anxiety between ethnic minorities and dominant groups as opposed to a shared identity (Shibutani and Kwan, 1965).

In fact the social incorporation of high skilled Indian professionals has been further complicated by the attacks of 9/11 in the United States. Research shows that after 9/11, a number of South Asians are viewed as suspicious and having links with terrorist organizations, notwithstanding their religion or nationality (Bhatia, 2008). The racial and ethnic profiling of South Asians following 9/11 is a reflection of the existing racial and cultural barriers in the United States that ostracize even the economically proficient ethnic groups (Dhingra, 2007; Dhingra, 2010; Kibria, 2002; Purkayastha, 2005a; Tuan, 1998a). Second-generation Reeta recalled how post 9/11 "everybody was being lumped into one category based on their skin color" and all brown cars had eggs and rocks thrown at them. Studies show how hate crimes against Sikh men of Indian origin were legitimized when they were described by some radio stations as "wearing

‘towels’, ‘diaper heads’ and ‘cloth heads’”(Bhatia, 2008:29; Purkayastha, 2005a). Several South Asians articulated their fear of being in public places and using public transport, and were advised by their friends and members of their family to quit wearing traditional clothing and to reduce their visibility in the public space (Bhatia, 2008). At the professional workplace, my findings confirm that 9/11 made Indian physicians increasingly vulnerable in their interactions with their patients. Both the generations of Indian physicians in my interviews collectively felt discriminated overtly or indirectly by their patients at some point of their career. In fact first-generation Saachi shared how her religion, and being a Hindu is important because Americans in and outside of the workplace as well “are relieved to hear when they see your face that you are not a Muslim somehow…the tone changes a little bit, that okay you are not as harmful somehow.”

My interviews with both the generations of Indian physicians also testify to their discriminatory experiences in the form of poor service in department stores, upscale restaurants, and in their interactions with luxury automobile dealers ‘as they move into traditionally white public accommodations’ (Feagin and Sikes, 1994). Discrimination in restaurants has recently incorporated ‘long waits while whites are served’ (Feagin and Sikes, 1994). Racial profiling by police officers also emerged as a unanimous area of concern considering how ‘blackness is considered a sign of possible lawbreaking by police officers’ (Feagin and Sikes, 1994). Asian Americans are perceived as a ‘non-white racial category consisting

of phenotypes that are usually seen as being identifiable relative to whites' (Kim and Sakamoto, 2010; Xie and Goyette, 2004:935), My interviewees indicate that they are more likely to be racially profiled by police officers while driving and in airports, irrespective of their skin tone. My findings demonstrate that in contemporary America discrimination and racial stereotyping of Indian physicians occurs independently of their professional identities and socio-economic status, and more importantly, overlooks the generation gap.

Besides, the level and the extent to which second-generation Indians are able to assimilate themselves is significantly influenced by the social incorporation of their parents and 'by the strength of the attachment that the child feels to the parents and to the parents' national origins' (Rumbaut, 1994:756). This is apparent among second-generation Indians who still hangout with "whoever their parents exposed them to as far as family friends," and discriminate by religion in their personal interactions, unlike the first-generation who hold on to caste hierarchies. Inter-group discrimination of ethnic minorities by dominant groups and intra-group discrimination within the Indian community, both play an important role in determining incorporation of Indians at the workplace. Omi argued, "I don't think it is something that is explicitly said. I think it's just the way people behave. You can be professional with someone at work; you just don't have to invite them to dinner. And you won't invite them to dinner. So if you have a Muslim colleague at work, and you are not a Muslim, you are Hindu, you probably will not invite them to dinner…same with if you are a White

versus if you are non-White….” Min and Kim (2009) in their study show how Indian respondents mostly limit their close friendships to their sub-ethnic groups, based on religion, national origin, regional origin and/or language. By classifying the incorporation of immigrants and their descendants either as assimilation (Handlin, 1951; Park, 1930; Park and Burgess, 1969) or cultural pluralism (Alba, 1990; Gans, 1979; Gordon, 1964; Waters, 1990) the predominant theories in the United States, often overlook how their ethnic identities are built as much by the sending countries, as by the receiving countries, across generations. In identifying a new process of migration, scholars of transnational migration emphasize the ongoing and continuing ways in which current-day immigrants construct and reconstitute their simultaneous embeddedness in more than one society (Schiller, et al., 1995). As a result, numerous migrants today continue to cultivate robust transnational ties to more than one home country by forging and sustaining simultaneous multi-stranded social relations that link together their societies of origin and settlement. Their ‘daily lives depend on multiple and constant interconnections across international borders’ and their ‘public identities are configured in relationship to more than one nation-state’ (Schiller, et al., 1995:48). As second-generation Shyam who travels frequently to India acknowledged, “Its also nice to know that I have this home across the globe….”.

Moreover my research findings on the social incorporation of second-generation Indians, their experiences and conflicts within themselves and with the first-generation, defy being categorized as either anomalous (Saran, 1985) or

heralding incomplete incorporation (Kar, et al., 1996) or even segmented assimilation that is usually marked by conservation of values of the immigrant community and strong solidarity, when accompanied by rapid economic success (Portes and Zhou, 1993). A majority of the second-generation in my study, despite being fully aware of traditional Indian values, experienced constant conflict in "how Indian and how American you wanna be, and what those definitions mean to you". As Omi explained how "from childhood it's been a conflict the whole time, because your parents say one thing, the culture says something else…everyday is a conflict like that. What you eat, how you dress, what you do on the weekend, how you live your life at school, how you live your life outside of school, how do you live your life outside of work, what do you do at work, every single thing is a cultural shift, and a cultural conflict…I think everything we do there is a conflict, every single thing, down to the food you eat…I think the conflicts occur in how you are going to raise your children…so you and your spouse have to be on the similar page." In fact just within the second-generation there were varying interpretations of what it really meant to be an Indian and different moral barricades upheld and practiced by each family. The first-generation reported fewer of these identity conflicts and usually appeared quite clear-cut on what paths they would want to choose and would like their children to follow, unlike their second-generation counterparts.

Dating, Marriage, and Women

But for the first-generation women as my findings demonstrate, the transition to America “just happened as a matter of course” and their work-life struggles at home were more internalized and less recognized by even them as problematic or discriminatory. They had to be equally efficient at work, as they would be expected at home in the United States, which would still be run like traditional households in India with unequal sharing of responsibilities between the spouses, with women usually shouldering the greater burden. They were socially conditioned by their families in India to never question their added responsibilities and take them as a part and parcel of married life and of being a good and chaste Indian wife and mother. Rebelling, or questioning their added burdens would prove them to be otherwise and would not be a good reflection on their upbringing or on their parents. While the second-generation women that grew up in the United States, after having observed the chasm between patriarchal Indian practices at home and the far more liberal and empowering American lifestyle outside were far more conscious, articulate, and comparatively proactive about their dilemmas and struggles of blending home with work.

Finally, dating and choice of marriage partners proved equally tumultuous for the second-generation, often conflicting against their parent’s beliefs on propriety. The reason being that ‘in India, older generations stigmatize free and unsupervised mixing of the sexes as improper and promiscuous. The rigidity of sex segregation, however, varies with class backgrounds and the particular subculture of a family’ (Gupta, 1997:584). As Harvinder explained how Malyali

[originating from the Indian state of Kerala] fathers had clear “double standards” motivated by an “overwhelming fear” of “having their daughter get pregnant unwed”, that led to a “tight grip over their daughters.” In fact Saroj was constantly told by her mother that daughters had “so much to lose” and like Dolly “had to live by a different set of rules.” So much so, that Nandita felt that a growing number of Indian Americans, that are second-generation just stay single. “Because ultimately they would probably be happier with an American but their parents would never accept it and they don’t wanna disappoint their parents…they [parents] think we are the same as them, they think what makes them comfortable will make us comfortable. But they don’t realize that we grew up in a completely different world than they grew up in. And so we are not the same and we don’t have the same ideas of home and comfort. So like out of love they are ruining our lives, [laughs], completely, unacceptably. ”

My research shows that qualifying incorporation of skilled professionals, first and the second-generation, as segmented or as towards or away from the American mainstream is too simplistic an approach to understand the assimilation process of Indian physicians in the United States. It overlooks the underlying prejudices behind their ‘rapid economic advancement’ (Portes and Zhou, 1993) that curtails their socio-economic mobility and incorporation, and the ‘social costs’ that they are required to pay through their own internal struggles and conflicts. To even suggest that social incorporation, just requires “‘culture shedding’ or ‘some behavioral shift’ or the ‘unlearning of one’s previous

repertoire'" (Bhatia, 2008:37) overlooks the multiple, contested and sometimes agonizing processes involved in gaining social acceptance at the workplace and beyond, even for human-capital immigrants and their second-generation descendants of color. Moreover, for physicians of Indian origin, social incorporation continues to be affected by the inter-dependency required in and outside of the medical workplace, and thus on occasion is affected by abuses, yielding differential results for the established members and the newcomers.

Chapter 6

THE DILEMMA OF RETURN

Portes and Rumbaut (2006) argue that high skilled professionals emigrate largely because of the increased *relative deprivation* that they have to counteract in their developing countries. Relative deprivation is often motivated either by the incomes of potential immigrants, which may be less than their professional counterparts at home, or by the lack of employment opportunities and good working conditions that complement their professional training and aptitude (Alarcon, 1999; Portes, 2009; Portes and Ross, 1976; Portes and Rumbaut, 2006). This promotes '*structural imbalancing*' between the developed countries and nations that are still on the path to development by preventing them from preserving their domestic labor force (Portes, 2009; Portes and Walton, 1981; Sassen-Koob, 1988). Portes (2009) argues that most developing countries aiming to modernize along the western path, train their professionals according to first-world standards; but they are unable to create comparable opportunities to absorb their trained manpower. This in turn creates and contributes to the 'relative deprivation' experienced by these trained professionals who in turn seek their professional outlet by emigrating to first world countries that are already short of high-skilled domestic workers.

Although studies show that emigration of high skilled workers from developing countries may not always be an anathema to national development,

but may actually contribute towards it by the transnational exchange of resources and ideas from the emigrants (Saxenian, 1999;2002;2006; Vertovec, 2004). However such transnational development can only come about if the receiving countries have the requisite infrastructure to absorb these resources (Portes, 2009). Besides, critics also contend, that emigration alone has not been successful in eradicating poverty by reducing competition in the domestic labor market and thus lifting sending countries on to a higher human development platform (Castles, 2004; Portes, 2009; Reichert, 1981); even though neoclassical theorists perceive of immigration as a mechanism to reinstate the natural equilibrium between high-wage and low-wage countries (Borjas, 1989;1990).

This is evident in the dilapidated state of the health sector in India despite large-scale emigration of physicians. India being a developing nation, is besieged with the predicaments baffling even the first world countries, such as urban and rural disparities in health and overall socio-economic development, and a poorly-equipped national health sector unable to withstand the HIV/AIDS epidemic, along with leprosy, malaria, tuberculosis, and other contagious diseases (Konana, 2006; Mullan, 2006). Worsening the already precarious state of health, India being the second most populous country in the world has a life expectancy at birth of 64 years, and an infant mortality rate of 53 per 1,000 births (PRB, 2010). Studies show that in India ‘an infant born in the poorest quintile of the population is two and half times more likely to die in infancy than an infant in the top quintile and four times more likely to die in childhood. An adult from the

poorest quintile is six times less likely to access hospitalization, and a pregnant woman, more than six times less likely to be attended by a medically trained person than their counterparts from the richest quintile' (Mullan, 2006:384). Similar disparities in health outcomes are replicated between urban and rural populations. With a huge sub-section of the Indian population lacking access to basic healthcare, prolonged large-scale exodus of physicians from India heralds detrimental effects for national health care. What is worse, assertions about the adequacy of the Indian health enterprise refer to the private sector that essentially panders to the rich and urbane, and not the public sector that is ill equipped financially and in terms of basic infrastructure and health professionals, and caters to the poor (Mullan, 2006).

From the perspective of brain drain, emigration of Indian physicians has resulted in a profound loss of highly qualified professionals for India. Although comparative studies on return migration of health professionals are scarce, scholars argue that return of high skilled workers is low considering their greater than before quality of life and living standards after migration (Clemens, 2009). The All India Institute of Medical Sciences (AIIMS), located in New Delhi is India's premier medical school. Research shows that 56% of the physicians from AIIMS emigrated during 1956 to 1980 (Adkoli, 2006); as did 54% of the 1989–2000 graduates, 85.4% of whom emigrated to the United States (Kaushik, et al., 2008). And among the 1996–2000 AIIMS graduates 'only one of the emigrating AIIMS graduates returned to India and that was for just 1 year' (Kaushik, et al.,

2008:42). The only available route then for developing nations like India seems to be in encouraging the return migration of their high skilled immigrants. However, return is critically affected by the 'initial motivations for migration as well as by the duration of the stay abroad and particularly by the conditions under which the return takes place' (Cassarino, 2004; Ghosh, 2000a:185). Although emigration of Indian physicians to the United States has been studied in a few works (Jeffery, 1976; Kaushik, et al., 2008), yet it lacks an in-depth investigation of the factors promoting such large-scale emigration of physicians from India.

While the structural imbalance between the U.S. and India that encourages physicians to emigrate from India still exists, the last decade has brought exponential growth in the Indian economy (Mohan, 2008) with a rapidly growing Indian middle class, development of health insurance (Devadasan, et al., 2006; Ellis, et al., 2000; Ranson, et al., 2006), and also medical tourism. Moreover an increasing number of highly reputed medical institutions in the U.S. are developing collaborations with their Indian counterparts. For example the M.D. Anderson Cancer Center in Houston, Texas, has partnered with the Tata Memorial Cancer Center, Mumbai to support collaborative translational cancer research and educational exchange such that the Tata Memorial Cancer Center is considered a sister institution (MDACC, 2012). At the same time, the economic recession in U.S. has made it more difficult to find and retain jobs including those in the medical profession (Johnson and Evans, April 13, 2009). Moreover in response to the ongoing disparities in healthcare and rising costs, there have

been significant changes in U.S. legislation including the Patient Protection and Affordable Care Act as well as the Medicare cuts that have lowered physician reimbursement by up to 30% (Gruber, 2010). These changes mirror those seen in the information technology field where return migration of Indian professionals or the “reverse brain drain” has started to concern many (Chacko, 2007; Wadhwa, 2009). Whether a similar phenomenon of “reverse brain drain” is about to occur among Indian doctors practicing in the United States is not known. Since most of these developments are relatively recent, evidence from earlier research may not be applicable in the current context.

Moreover, most research on return migration seeks to understand the cause of migration and motivations to return, by asking the immigrants their reason for return (Gmelch, 1980). However such studies are inclined to be inadequate, as reasons for return cannot be attributed to one factor alone, as return is a cumulative outcome that is prompted by a number of factors at work (King, 1978). At the same time there is a dearth of research investigating why physicians may opt not to return home and develop into agents of change, when viewed against those who do. It is only with the amalgamation of both the perspectives that we can truly comprehend the factors that govern immigration and return of Indian physicians. Considering the undeniably immense impact that return of Indian physicians from the U.S. can have in enhancing and contributing to better health outcomes in India, more research is needed to understand what

factors deter return and differentiate physicians who stay back from the returnees.

RESEARCH QUESTION

My primary research question is "What factors deter first-generation physicians who emigrate from India to the United States from returning back?" In this chapter, first I will examine the underlying causes that deter first generation Indian physicians from returning back to India from the United States. Then I will explore medical tourism in India as a potential route for physicians to return back to the country. Finally, I will look at the dilemma of return that each of these physicians face, yet opting to stay in the United States despite the racial and gender based discrimination that they encounter. The sections which follow address findings of the three major issues that emerged in my interviews.

FINDINGS

What Makes Return Impossible?

The majority of the physicians interviewed for this study either did not want to return back to India, or were more inclined not to. Out of the 50 first-generation physicians interviewed for this study, only 6 wanted to return back to India, 2 of which are married to each other. The reasons advanced were the poor health infrastructure; limited options of practice for various sub-specialties, and the unethical, disorganized, and corrupt medical environment in India. Deepesh

asserted that his chances of going back were slim. “What I am doing here is highly specialized, so I have done Gastroenterology and then I have done an extra year of advanced endoscopy training. We do these kinds of procedures in India but only in big cities and I want to do more of cutting edge research in the field of advanced endoscopy which would be limited in India.” Likewise Abhay, Viraat, Mangal, Jagrati and Pahal all agreed to how specialized training in India was still in its infancy with very few comparable opportunities in the sub-specialties that they practiced, e.g. Neonatology, neuromuscular disorder, infectious diseases or healthcare epidemiology.

Vicky and Prakash felt that the medical practice is India was politically motivated in government hospitals and corrupt otherwise, which would leave them little options of returning. Vicky explained, “the reasons I would not want to migrate back would be one: economic, two: it would be just the working conditions. The working conditions here are far better, people are more professional…here I would say merit is a very strong consideration in how you are promoted and how well you do in your career, while back in India most positions are politically filled rather than based on the merit of the person, so that can be a very frustrating thing.” Likewise Prakash concurred, “…if I go back to India, I probably will be going back and working underneath somebody who does not understand medicine. Or since I don’t have post-graduate from India, I just have done medical school; I have to start all over again, if I were to work in a government place. If I work in a private place, I do not want to work in a private

place because I have a dilemma in which I don't want to practice medicine because hundred percent it's because of money, that will be the wrong thing to do. So going back to India and in many places you will find the appointments are definitely made based upon whom you know."

In a similar vein Savita and Suneeti outlined the questionable medical practices followed in India along with the measly allowances given to physicians in government hospitals, which compelled them into staying in the United States. Similarly, Rachna, Manika and Sana attested to the lack of "seed money" that discouraged most physicians to start up their own private practice in India. Savita felt, "…it wasn't that easy to find jobs, unless and until you are going to private practice. Again the private practice there at that time was not the best, not the standard of care… there is a lot of politics, there is a lot of underhand dealings, lot of fooling the patient, or misleading the patients, and really serving your own den rather than taking care of the patient. I think that is what kind of makes it look bad and makes you not being comfortable with that, because if you are not comfortable doing all that then there are very limited options. And even the government set up is pretty bad, and you know they don't pay you much…and if you are not practicing then they give you a very measly allowance for that, so it is really hard to make your ends meet in a government job there, until and unless you are doing underhand things…And again you don't have the resources, you really cant do much, your hands are tied because you don't have all the medicines, you don't have all the supplies, as you try to make do with whatever

you have. Make the best of the situation which may not be the best way out, or you ask the patient to pay which again is not right…I don't think that it's a problem that can be easily fixed because of the way things are."

Likewise Sampat elaborated on the nature of the medical practice in India and how "…physicians have to compete with quacks to get patients. There are not enough patients who can pay a good salary for a doctor. So doctors compete a lot for patients with resources, and they pay money to other physicians, or quack, or to whosoever that can refer patients. Patients get referred by medical stores…this is especially true for referral based specialty…secondly it is kind of a trading of patient; to generate your own business you try to snatch away patients from other physicians…then if you admit patient to the hospital, you get commission from the hospital, because the hospital generates revenue out of patient. So you have an incentive to hospitalize the patient. For one unnecessarily they are hospitalizing them, for two, hospitalizing them for a longer time, for three, hospitalizing them at a level of care they probably don't need…doctors are not reimbursed according to the level of their training, and I think that promotes corrupt practice…"

Ironically when in India, although Suneeti like Aarti, did try to opt for a different route out of the corrupt medical pattern of work, yet it did not go down too well within the set up she functioned in, and eventually backfired against her. She elaborated, "In fact there was a time when for four, five days everybody

started withdrawing patients from my practice because they learnt that I wasn't going to give them the kickback fees, and they were all upset. But I said whatever the condition maybe I am not going to give it to them, and my administrator in my practice said that they are going to close the practice because that's how everybody works. When we will refer for the imaging testing they will give back the kickback to us, and I refused to take that money also, then everybody was like, 'what's wrong with you?'" Subsequently, like Anandita, Savita felt that if one did not want to do that kind of private practice, then there was very limited option in India.

Viraat, Rachna, Padma, Saachi and Kirpal also felt that Indian medicine reflected a "loss of touch with the reality there" with "no quality control" in the pharmaceutical industry. Pahal and many others also argued how "Indian medicine is not organized around asking questions and investigating issues, it's more of a follow the book sort of a thing," with "the multi-disciplinary approach to medicine" lacking in the country. This was also accentuated by the absence of other support services like chaplain services,[10] interpreter services, social worker, case manager, and financial adviser that were still underdeveloped in the country. With "organizing care around the patients needs" missing, physicians often did not disclose medical complications or shared any information with

[10] A chaplain is a minister, representative of a religion working in a specialized setting and is attached to a secular institution such as a hospital; for example a pastor, priest, imam, or rabbi.

patients. Palliative care service also remained dormant with the state system being on “auto-pilot,” and the private system organizing itself around profit.

Finally the relatively superior quality of life in the United States and the greater financial autonomy that physicians experienced as opposed to the lawlessness, and corruption prevalent in the day-to-day life in India, further solidified their resolve to stay here. Madhav argued how physicians got “very entrenched in this culture and this society” and it became difficult “to go back and restart” particularly considering how he would not be able to replicate his academic career there. Similarly Savita explained how “once you are becoming more independent then you kind of get used to it, and once you have kids its harder to move back…but probably a better quality of life because you don’t have to worry about day to day living as you had to in India, I think that’s the strongest point. And once you get to all these conveniences here…I think it’s hard to go back to that again.”

Medical Tourism: the Reality Minus the Myth/Hype

With the healthcare costs skyrocketing in the United States, India is fast emerging to be an international destination for medical tourists from the United States and other parts of the world. The medical tourism industry in India is also largely touted as a potential avenue to enable return migration of physicians from countries like the United States. Gomti was optimistic and felt that “there are centers of excellence there (India) and wide disparity in the quantity and quality

of care that's provided. I think for the most part they (hospitals for medical tourists) were founded or for the most part staffed by physicians trained here, and who have returned. And I have heard it's the state of the art care that you get there. They have all the facilities that can be found here." Komal too concurred that it could lead to return migration. "Because I think that in terms of providing quality of care, that you can provide equivalent quality of care at lower costs. So just by an economic model it is definitely very attractive." Likewise, Alok anticipated that medical tourism would be "happening in the next 7-8 years, and I think at that time maybe we can go back." Avtar too reiterated, "when I was in Apollo [hospital in India] we had physicians who were trained here in U.S. on J1 visas, and instead of doing waiver and trying to settle they went back…definitely it is happening and probably it will increase more…At least radiologists they actually prefer to live in India, because they can get the salary from here but live there, and enjoy all the socio-economic benefits of being in India… with health care schemes coming in the U.S. the reimbursement here decreases, then India becomes more attractive."

On the other hand, Charan who went back to India from the United States felt that medical tourism was incapable of promoting return migration of Indian physicians. He explained, "the only thing that it is promoting is that now there are big hospitals [in India], just like the hospitals here [in U.S.], big corporate hospitals coming up in India, where the conditions are the same or in fact better in some hospitals compared to U.S… medical tourism is not as much that you

can live on it, it is like you will get one or two patients in a month. I don't think anyone is going to migrate based on medical tourism." Similarly, Savita concurred, "I think in the last couple of years there have been a lot of new hospitals, more like these chains coming up in India, where they are asking for a lot of investment from these NRI's [Non-Resident Indians]…but that's again in only cosmopolitan cities…but I haven't heard of anyone kind of going back or taking up a job offer there… but it hasn't caught on yet, I don't think so."

Suneeti on the contrary was skeptical because she felt that India had enough physicians to cater to medical tourism, "so why would somebody like to go from here if you have a decent work situation here, to go back and work there? I think majority of the population just stays where they are, and acquire services where they are…" Furthermore like Deepesh, Sampat argued that medical tourism was at best a very limited option to begin with. He explained, "…It cannot apply to emergency health care. Most of the hospitalized health care in the U.S. is emergency care and its not elective care. Only procedures that are elective and reasonably expensive in U.S. can be outsourced. But if you look at current hospitalizations, most people get admitted to the hospitals through emergency rooms. And those procedures cannot be outsourced. So medical outsourcing will not constitute a large proportion of U.S. healthcare expenses." In addition, Deepesh felt that it was too early to "say whether it will take off or not, because eventually things like follow-up, complications, and all those things we

will have some papers or studies on what happens on a long term follow up and that will decide whether medical tourism really takes off or not."

To make matters worse, some physicians feared that the inherently corrupt medical practice in India might not let medical tourism take flight ever at all. Sampat argued, "…There is a difference in the level of professionalism that exists in India and in U.S. To an extent both the societies run on similar models, basically it's for profit, private hospitals in U.S. are for profit, and the same is true for Apollo and other hospitals [in India] that take care of the medical tourism business. But the laws in U.S. are much stricter than the laws in India, there is a lot more potential of malpractice in India compared to U.S., and the medical practice overall in India is extremely corrupt. I wouldn't say that the practice in U.S. is extremely fair either… But still in the background there is some concern about the patient either out of choice or out of fear of legal penalty or lawsuit. In India there is no such fear. The only fear that exists in India is that if there is any bad outcome there would be a mob that would torture hospitals, break your bones, or throw the doctors down from fifth floor or seventh floor and kill them…so there is a different aspect of fear that exists in India, and that aspect doesn't prevent corrupt medical practice." In a similar vein Prakash concurred, "I think it's [medical tourism] a very philosophical question. Practice of medicine though it is becoming more and more business, it inherently is not business. People go into medicine because they really do want to help people. Medical tourism, its premises is payment for performance. Meaning that you give me

service and I will give you money. It is good, but my own feeling is that people who are practicing that kind of medicine in India, are truly may not be keeping the best interest of the patients utmost, top of the list. See Apollo hospital is not in the care of doing charity."

Overall medical tourism did not emerge as a possible outlet of return for physicians, because of its limited options and also because of the way it is practiced in India. Saagar, Shravan, Mangal and Abhay doubted if it could actually provide a quality life to physician returnees and did not feel that it could actually encourage them or others to return migrate. While Kirpal, Raghav, Nagesh and Viraat felt that medical tourism had a very limited scope in terms of only certain surgical specialties that it could appeal to instead of ophthalmology, transfusion medicine, or neonatology and many other branches that physicians like them practiced. Moreover Komal, Charak and Saachi feared that it would be very hard to navigate in India, considering how medical centers would try to squeeze a lot of work from physicians and not compensate them adequately coupled with a hierarchical medical structure where seniors humiliated and snubbed their juniors. Rachna also found the sterilization techniques, patient's safety, hygiene for post-operative infections, and prevalence of counterfeit medicines as the possible factors that could stall medical tourism from actually taking off in India.

Interestingly it was Aarti who confirmed the skepticism, and fears advanced by Sampat and Prakash, and all the other physicians in my sample. Aarti had worked in India from 2003 to 2005 at Apollo Hospital considered to be the hotbed of medical tourism in India. And having worked there, she felt that India was at least a decade behind in providing the same kind of medicine as the west. Although a doctor may perform the best of surgery, yet if the post-operative care was not optimum the surgery was not going to be as successful as in the U.S. She explained, “see, because of my visa status I came on H4 and then I went back on J1…I went to India for two years in order to convert my visa. So I worked at Apollo, and Apollo is one of the hubs of medical tourism. So I was a consultant physician at Apollo. So I had an opportunity to see it from that side. And ya they do really have the infrastructure, they have the best of physicians, but what is lacking is the ancillary services. The nursing is by no means anywhere comparable to what the west has to offer. There is no concept of respiratory therapist. They have the best of ventilators, but they don’t know how to use them. A physician alone cannot function. He or she needs a team to provide the quality care that makes the western medicine so appealing. And that is kind of still lacking.”

She also elaborated on how medicine is treated differently in India. “The highest antibiotic is given for any ailment regardless whether that is required by that patient or not…the nursing that exists is pretty pathetic there. It is nothing compared to what you have here…here my nurse says something, especially few

of my experienced nurses, I will listen to them, and I will often take their suggestions and put them to practice…they are very much an integral part of our team… they are basically there [India] to take care of the physical needs of the patient…clean them, bathe them, give them injections…I can't provide care to a patient unless I have a 24/7 team providing that kind of coverage. I would need partners who would share that 24/7 coverage with me…then the whole approach is that the patient has to be 'fixed', is the term that they use. You have to cure him as fast as possible because firstly there is no medical insurance, so the parents are footing the bill for the child. And if it's a girl child, and if it's a socio-economically compromised family, its not gonna happen…and if it comes to a girl child, then definitely they are not gonna shell it out. So those are issues that you don't have to face here...there I had to deal with, 'okay, how much money will it cost, upfront?' even before the child is placed on the bed. 'How much time do you think it will take?'… Since it's the money the parents are shelling out from their pocket, they want the child to be healed as soon as possible. And throw whatever you can, throw the entire kitchen sink at them but get her or him out of the hospital as soon as possible, and that's not how we do things…there's a method to the madness you know…it's a totally different mindset… Ya the doctors maybe lured by the money and the social infrastructure that you have in India. But you would not have that level of satisfaction that you have at work here."

Vanessa, a senior faculty in an administrative position agreed and felt that people in the United States thought medical tourism in India to be “a little sketchy. And I don’t think that I would encourage someone to go back to India and do that just because my perception is that a lot of the things that are done are either not necessary, you know plastic surgery things. You also hear horrible stories about follow-up. People have complication from their procedure that is not followed up well. So I think if the reputation of that industry were better, then it might be more attractive.”

The Dilemma of Return

Despite intending not to return back to India in the immediate future, many of the research participants had not completely ruled out an opportunity to go back. While for some there was the compulsion of old parents waiting at home, yet the others wanted to go back for a better social life. Prakash reiterated, “I am still digging in the U.S. partly because of career reasons that I don’t get the opportunity to do research and practice cutting edge medicine and being in a University. Because in India health care is not under a university, it’s either a private practice, or at a hospital, you don’t have that freedom. Here I get the best of both worlds, taking care of patients and being at a university. So after having fulfilled my dream of the career part of publishing and stuff like that, I would definitely want to go back to India.” Alok felt that his “parents are getting old, so I think that I should go and live with them…” Deepesh on the other hand explained, “The only reason that would make me go back is family reasons…I

haven't really consulted them, and they give me their opinion, but it doesn't really matter a whole lot. He (Dad) is fine with it, because he is looking more at it from a professional standpoint than from a personal or family standpoint. Having said that, if they don't join me, I mean they are getting old, so few years from now they will be old enough that somebody has to take care of them, at that point he will have to decide. At this point he says he will come to U.S. eventually, but who knows, he probably may not."

Rajesh like Komal however wanted "to go back to India because of a better social life." Komal explained the dilemma he was in, "I think there are two reasons: mainly the social factors and the other possibility that the opportunities in India are several. But the uncertainty comes from the fact that the current medical system in India is not very conducive to research and I am a little worried about that….I have not decided that I will go back to India, but there is a very strong possibility that I will." Likewise expanding on his discomfort in bringing up his children in the American social environment Sampat concurred, "the only reasons that I would prefer to go back to India are actually two: one is that my parents are there, my family is there, and without any family it's not fun staying in U.S. It's a very socially isolated society where you work, and make money, and then don't know what to do with it. And second is that I would be very uncomfortable bringing up my kids in U.S. I grew up in India and I am much more comfortable with the education pattern there and with the cultural pattern there and I would be much more comfortable in interacting with my children and guide

them in their life and career in an Indian environment. I am not accustomed or used to U.S. environment and even after staying here for six years I don't really know what social life in U.S. is really like…professionally there is absolutely no reason for me to go back…"

Chander, a Keralite Christian, was the youngest son of his family who would inherit his family house in Kerala that served as the primary motivating factor for him to return back and take care of his land and house. Kanav and her husband Maalav also planned to return back to India after having achieved their career goals in the United States, for a better social life in India where they could relate more to the cultural and social lifestyle. They did not really enjoy the American lifestyle of going to pubs or parties; and felt they would be happier in India being with their families. Maalav wanted his children to be more Indian and appreciative of the Indian culture which was only possible by being in India. He also felt patriotically wanting to give back to India by going back and practicing medicine there. On the contrary Avtar was considering migrating to Singapore, where he felt he would receive "a better socio economic…more importantly socially where I am better assimilated than here."

The women participants in my sample however gave mixed responses on return migration to India. Anandita and Aarti both had decided against returning because of their husbands. Aarti felt, "I would love to, but no my husband doesn't want to…there are corruption issues, but there are lot of people who chose to

practice by different set of principles. Then they are not as successful as the others who feed the hand that supports them." Saachi, Padamja, Gauri, Pamela, Rachna, Jagrati, Sana, Komal, Pallavi, and Smriti, all had decided against returning back to India for better career opportunities and lifestyle in the United States. On the other hand Gomti, Savita and Suneeti were considering splitting their time in their old age between India where they had family and the U.S. where their children were growing up and would eventually settle. Gomti explained, "I would like to [visit India] sometime. Now that my children are both in college and they don't need me that much and my hope is to at least spend a few months a year there, I wont be working twelve months a year here, I would like to do some volunteering there and work as a doctor and volunteer my time at least one or two months a year, and go spend some time with my family…I will probably have one foot here and one foot there."

Likewise Savita concurred, "maybe in my old age yes, when the kids have grown up and all gone through college because at this time I have kids who are in high school, obviously kids are coming from India to U.S. for college education, for higher education, so it would be silly to go back now and take the kids back home, it just won't work…to lead a retired life there, six months here, and six months there, maybe that's an option…" In a similar vein Suneeti felt, that "when you retire then there is no point staying here because all the friends and family is in India, and the social support is much better in India…children will probably stay here, then you can come back and go back…" With their spouses and

children residing in the U.S. whether they will actually be able to live a transnational life and hop from one continent to the other 8,000 miles away, as they get old, and when one desires more stability and permanence; or if India will continue to survive as just a nostalgic flavor in their lives, only time will tell.

DISCUSSION AND CONCLUSION

Among the high-skilled immigrants, physicians are regarded as 'one of the most expensive professionals to train' (Portes, 1976:497). It is the superior undergraduate medical training[11] imparted to doctors in India that largely prompts physician emigration from the country. They find that comparable opportunities and infrastructure to either put their training into use or acquire advanced training in sub-specialties is either lacking in India or concentrated only in urban cities where there is already an overflowing physician population in medical colleges and the job market. Porte's (1973) characterizes such emigration as essentially modern. It encourages professional migrants trained according to first world standards to develop high ambitions. Yet failing to find comparable opportunities at home, they leave their home countries behind in search of a better quality of life (Bhattacharya, 2008; Bhattacharya and Schoppelrey, 2004; Zhou, 2004b).

While majority of my respondents expressed a desire to return to India, the challenges of uprooting their family and resettling in India often are significant

[11] India houses some of the best medical schools in the region offering internationally comparable medical training at the undergraduate level. However what are lacking are competitive training opportunities in specialties and sub-specialties at the graduate level that compels many physicians to emigrate for advanced training.

enough to overcome the emotional bond with India. Although emigration is strongly dictated by motivations for career advancement (Helweg, 1997), returning is often very challenging even for those that have strong family ties and have a strong sense of motivation. While migrant doctors struggle to assimilate in the U.S. society, 'adequacy of income, quality of jobs, number of jobs, and the interests of children' is what keeps them from returning back to India (Glaser and Habers, 1974:241).

Most of my interviewees immigrated to the United States after completing medical school and had little or no experience of working outside of their training program. This unfamiliarity with the system, along with widespread prevalent corruption, lack of regulation, and hassles of daily life emerged as other important reasons that deter return migration. In Sahai's class in medical school, one-third of his cohort emigrated abroad. Although most physicians emigrate intending to return to India, yet familiarity with U.S. medical practice and lifestyle, and better clinical and academic opportunities make return a remote possibility (Mullan, 2006). Also, as many of the respondents said, getting married and having children reduced all the chances of return for physicians. Many foreign graduate physicians who do return find it difficult to continue their style of practicing medicine or find comparable avenues for their highly specialized skills, compelling them to prolong their stay in the United States or to re-enter again as immigrants (Dublin, 1972). Nagesh who was one of the very few physicians who plans to return back to India after the completion of his training in the U.S.

explained that he would go back to India only because he felt that he belonged there and “it’s home.” But when it came to reforming the health care sector in India, and the government making efforts to make return an attractive option for physicians abroad, he argued, “Even if Indian government wants to do something, it will never be implemented, at least in my life, because the execution in India lacks. Everything is on paper but nothing is executed.” Likewise Lindsay, a senior faculty in an administrative position argued, “India is a huge country, so they have a lot of people, but they also have a lot of people that need doctors…and once they have come here and seen what kind of resources they have, what kind of ability they have to treat and heal people, I think some people find that it’s just easier to stay here than to go back.”

Contrary to popular perceptions, visa status of physicians also did not play any role in influencing their decision to stay in the United States despite the legal obstacles accompanying their visa categories. Though most physicians did experience the dilemma of returning back to India, the visa trajectories chosen by them contradicted their desire to go back, translating more into a struggle for obtaining permanent settlement in the United States. This was evident in the way Shravan, Smriti, Deepesh and many others acknowledged how visa was secondary to their decision to stay in the United States. Although the J-1 visa in particular did result in a lot of “road blocks” that did delay the career aspirations of Raghav, Maalav and Raju, and limited the professional choices of physicians like Prakash by barring him from private practice; yet it never weakened their

resolve to stay in the United States. In fact it was their decision to stay in the U.S. that influenced them to change their visa status. Nagesh who was on a J-1 visa argued how visa was not an issue if one was good, but just a little more paperwork. There were always ways around to manage it. In fact Manika and Aarti both went back to India for two years to do a J-1 waiver in India and came back. Likewise Prakash plans to return back to India but only temporarily for two years to fulfill his J-1 waiver requirement. Vanessa, a senior faculty in an administrative position revealed how she got "a ton of letters every year from people of Indian origin looking for fellowships so that they can stay here and keep training. The goal I guess is probably getting a job in an underserved area so that they can get a different kind of visa."

Finally, the spurt of medical tourism in India in the recent years has been touted as a dynamic avenue that would incite the return of Indian physicians from the U.S. and other countries. India's efforts to become a "global health destination" took off in within the last decade and according to the international management consulting firm McKinesy & Company has "immense potential" (Chinai and Goswami, March 2007). According to an estimate by the Federation of Indian Chambers of Commerce and Industry, the Indian health-care market will expand to between $ 50 billion - $69 billion by the year 2012 (Chinai and Goswami, March 2007) and the medical tourism industry itself will generate revenues amounting to $ 2 billion industry by the year 2012 (FinanceWire, 2006; PricewaterhouseCoopers, 2007). Currently there are several hospitals in India

that are accredited by the Joint Commission International, the international arm of the Joint Commission on Accreditation of Healthcare Organizations or by the National Accreditation Board for Hospitals and Healthcare Organizations. Some of these hospitals include the Wockhardt Hospitals, Apollo Hospitals, Max Healthcare, and the Fortis Healthcare Group. These hospitals claim to specialize in "art of healthcare" and provide cutting edge technology such as 64 slice CT and 3 Tesla MRI scanners, PET scan, and electronic health records. With treatments in India often costing less than one-tenth of the medical costs incurred in countries like the U.S.; specialties like orthopedic surgery, cardiology, ophthalmology, gastroenterology, urology, bariatric and minimally invasive surgery, cosmetology, and transplants have attracted large numbers of medical tourists or "patients without borders" (Milstein and Smith, 2006; PricewaterhouseCoopers, 2007; Ramirez de Arellano, 2007).

To promote medical tourism, the government has encouraged purchase of medical equipment at depreciated rates, low import duties, and expedited visas for medical tourists seeking to be treated in India (PricewaterhouseCoopers, 2007). In addition to the elective surgical procedures, information technology has made telemedicine – which involves remote consultation, monitoring and treatment of patients via internet based doctor-patient interface, an attractive option for outsourcing medical tasks that do not require the physical presence of a physician (Herrick, November 2007; Wachter, 2006). Without doubt these high-tech hospitals attempt to attract immigrant Indian doctors since their international

credentials and certifications improve the hospital's competitive position (Mullan, 2006). At the same time, return migrants have the prospect of earning substantial income while fulfilling their family commitments. Along these same lines, Alok felt that outsourcing of cardiac imaging to India could convince him to return back to his hometown where he can both take care of his parents and have a good professional experience. In addition to providing opportunities for clinical patient care, these hospitals are building collaborations with reputed international institutions to develop research programs. For example the Duke Clinical Research Unit (DCRU) has recently announced its partnership with the Medanta-The Medicity, to establish the Medanta Duke Research Institute (MDRI), a 60-bed early phase clinical research facility (DCRI, August 31, 2011).

However despite the momentous growth experienced by the Indian health tourism industry, most of the physicians interviewed for this study felt that although the practice of medicine in India gives you family life, it does not provide professional satisfaction. Even though collaborations for clinical research are being developed, most respondents felt that these facilities would not offer any meaningful long-term prospect to physicians interested in academic medicine. Due to lack of regulatory oversight, there continues to be mistrust and lack of public confidence regarding these international collaborations. One such example is the suspension of demonstration projects for Human Pappiloma Virus (HPV) vaccination in Andhra Pradesh and Gujarat after the alleged vaccine-related deaths of six girls who participated in the study (Sengupta, et al., 2011).

Some of them were also apprehensive about the sustainability of lucrative jobs offered to returnees by these corporate hospitals. Since salaries are closely tied to the revenue generated by the physician, salaries that are dependent upon medical tourists are also vulnerable to changes in international rules and regulations. For example Sampat was apprehensive that these corporate hospitals could entice return of Indian doctors practicing abroad by offering them attractive salaries, which if not supported by adequate revenue generation, would be subject to drastic reductions over next few months. It also appears that the expectations and experiences of Indian physicians residing in U.S. are quite different from those in the U.K. where recent changes in regulations have diminished career opportunities for Indian doctors resulting in return of large number of Indian doctors (Eaton, 2006).

Narayan (2011) also argues that the endorsement of health tourism instead of universal primary health care has actually been a conscious choice by the Indian government placing the market over basic health needs of the nation (Narayan, 2011). With the rapid expansion of medical tourism industry, there has been an increasing concern over the effects of gearing Indian health care system towards rich foreign patients on the impoverished and underserved Indian population (Shetty, 2010). One can also question whether return migration of a large number of western trained Indian physicians would really help solve the woes of Indian health system or worsen the already saturated job market in urban regions. It is reasonable to expect that specialists and sub-specialists who

are trained to use latest technology will find themselves out-of-place in the rural areas where there is greatest need of physicians (Mullan, 2006). India is at crossroads in terms of its own healthcare workforce, making issues of return migration of Indian physicians both a priority in medicine and a prerequisite for the development of its healthcare system in the 21st century. Undeniably, with respect to the ambition and talent of Indian physician's, their return can signify great promise for India, particularly in terms of the tangible and non-tangible benefits that accompany their return. Enduring return will necessitate making return migration a sustainable choice – since facilitating return is meaningless if physicians are likely to be compelled to emigrate again.

Chapter 7

CONCLUSION

Indians comprise the largest number of foreign medical graduates in the United States (Kumar and TB, 2007), and account for 4.9% of American physicians (Mullan, 2005). An important factor that plays a far more critical role in molding the migratory trajectories of Indian physicians than is acknowledged is the context of racial and gender based discrimination at the American workplace. I have argued that workspaces of Indian physicians in the United States are significant social spaces for the perpetuation of racialized and gendered norms in the workplace. Considering the centrality of racism in scarring the lives of physicians of color, what is conspicuous by its complete absence is much contemporary research on the workplace expériences of physicians of Indian origin in the United States. The lack of this acknowledgement could be attributed partly to the fact that, 'U.S. discourse on racism is generally framed in these simplistic terms: the stark polarity of black/white conflict (Sethi, 2003:154).' Conflicting experiences are classified as racial crimes only when they sufficiently bear a resemblance to the conventional presumptions. With their linguistic, cultural, national, religious, and color differences not conforming to the basis of a modified paradigm of racism, Asian experiences survive within the 'penumbra of actionable racial affronts' (Sethi, 2003:154).

As a consequence, the racial abuses Asians suffer are belittled; their reactions ‘are dismissed as hypersensitivity or regarded as a source of amusement’ (Sethi, 2003:154). Sethi ascribes this to three causes: First, Asians often do not assign racist intention to the discrimination they suffer, or they believe that they can endure the prejudice of racial bigotry, in return for being remunerated later by material rewards. Second, many Asians, and South Asians in particular do not identify with people of color, because of their ‘rigid self-perception as Aryan, not as people of color’. Third, the most determinate factor is the viewpoint that proscribes Asians from the rubric of racism. Whites would deny Asians their ‘right to speak out against majority prejudice, partially because it tarnishes their image of Asians as “model’ minorities”’. Other people of color would deny Asians ‘the same because of monopolistic sentiments that they alone endure real racism’ (Sethi, 2003:155).

Critics argue that the model minority stereotype is not really an indication of increased acceptance of Asians into the U.S. mainstream, but is an ideological apparatus to actually create and sustain the racial marginalization of Asians in the U.S. mainstream and brew resentment against Asian achievements (Kibria, 1998). Research shows that Asians are unable to achieve full equality in the U.S. labor market in lieu of fewer economic returns for their level of education when compared to their white counterparts and the glass ceiling that accounts for their absence in top executive positions despite their considerable numbers in such occupations (Espiritu, 1997; Fong, 1998b; Kibria, 1998; Purkayastha, 2005b).

Racial experiences of Asians are usually permitted to exist 'without remedy by legal recourse, collective retribution or even moral indignation' (Sethi, 2003:154). Verbal and physical attacks and overt discrimination are the most noticeable and intense forms of personal racism against immigrants (Matas, 1994). However my findings show that structural racism against foreign and U.S.-born Indian physicians is more indirect. Nothing racist is said when discrimination occurs, but the intent and its consequent effects are nevertheless discriminatory**.** Another form of discrimination experienced by first-generation Indian physicians as found in my study is accent discrimination. Discrimination based on perceived foreignness and foreign accents has been documented in qualitative studies (Fong, 1998b; Woo, 2000). This form of discrimination is pervasive and 'often not acknowledged as racist, or even offensive' (Sethi, 2003:156). Title VII of the U.S. Civil Rights Act of 1964 outlaws accent discrimination if an accent does not affect work performance. It is only since 1992 that courts have started to deal with issues of accent discrimination (Sethi, 2003). Non-European immigrants face heightened racism because of their accents including discrimination in jobs and constant taunting (Sethi, 2003). There is increased denial about the accent discrimination attributable to race, even among Asians (Sethi, 2003).

Although data on discrimination against practicing physicians in the United States remains sparse, studies have alluded to discrimination against FMG's with

respect to residency selection and as faculties in academic medicine (Balon, et al., 1997; Chen, et al., 2010; Coombs and King, 2005; Nasir, 1994; Price, et al., 2005). Purkayastha (2005b) argues that compared to their counterparts with credentials from the developed world, immigrants from former colonies are often held back. Occupational barriers are also set in with the less prestigious organizations accepting people with credentials from developing nations, whereas the prestigious organizations allow only Americans (Kofman, et al., 2000; Woo, 2000). The H-1B visa category that was comprehensively revised by the Immigration Act of 1990 for professional specialty workers, permitted certain FMG's to render patient care by obtaining the H-1B status (Kumar and TB, 2007). It also provided the foreign medical graduates with the alternative of pursuing advanced medical training in the United States for 'periods normally not to exceed seven years under a ECFMG Exchange Visitor visa (J-1) programme' that could be waived off by physicians and converted to an H-1B visa for professional specialty workers (Kumar and TB, 2007). Indians constituted the single largest category (56%) of H1-B workers in the United States in the year 2000 (www.immigration.gov).

This relatively new visa policy has created social environments for the practice of a new kind of racism in the United States, i.e., medical racism. Cutting across the generation divide, the first and second-generation physicians in my interviews, although with differing causal explanations, unanimously attested to the pervasiveness of an "overt bias" against FMG's, and "across the board

preference" for American graduates in determining access to residency spots, fellowships and faculty jobs. Saurabh commented, "there are 30,000 residency spots in the U.S., there are 18,000 American MD [Doctor of Medicine] graduates, and there are about 3,000 DO [Doctor of Osteopathic Medicine] graduates. So the other 7,000 or so spots have to be filled by foreign medical graduates every year. And those spots are always the spots that are left over after the best ones have been filled."

My research shows that Indian physicians in the United States are often perceived as 'shoddy practitioners, who are greedy and disinterested in the health of their patients' (Sethi, 2003). Asian doctors in the U.K. are frequently found guilty of 'professional misconduct and disciplined, whereas their white equivalents are either found not guilty, or are let off with a word of advice' (Richmond, 1993). The GMC's (General Medical Council, U.K.) attitude is 'that "chaps like them" are basically sound and should therefore be excused the occasional peccadillo, but ethnic-minority doctors are basically dodgy and must be carefully policed' (Richmond, 1993), a mindset that resonates in the American medical system as well. A case in point is Rajendra Badgaiyan, an assistant radiology professor at a prestigious university hospital in Massachusetts. He filed a federal lawsuit in 2004 alleging that he was discriminated against by the director of the residency program who made false claims about his performance 'because he is from India' and he might not get his license to practice psychiatry (Murphy, 2004). He was later issued a letter of apology by the hospital.

Soon after, three female Indian neurosurgeons who worked at a teaching affiliate of the same university hospital, filed discrimination complaints against the new chairman of the department, a respected and nationally known neurosurgeon (Kowalczyk, 2007). According to the lawsuit, Saigun Tuli, an assistant professor, said that the chairman 'denied her promotions and continually made demeaning statements to her while she was operating.' She also claimed that the chairman 'retaliated against her for complaining to his superiors and supporting other female Indian neurosurgeons and gave her an extremely busy operating and on-call schedule, while paying her less than her male colleagues and not giving her adequate time to conduct research' (Kowalczyk, 2007). A U.S. District Court jury found that she had indeed been subjected to 'numerous instances of harassment, ridicule, intimidation and abusive conduct' by the chairman (Sohrabji, 2009). While, in her 2007 complaint, Dr. Soni Deepa asserted that during the final year of her neurosurgery residency, she was 'discriminated against in several ways, including being provided fewer hours than her male colleagues in the operating room in the critical area of cerebrovascular surgery and being denied time off to attend professional meetings' (Kowalczyk, 2007). Another neurosurgeon, Dr. Malini Narayanan, claimed in 2005 that the chairman discriminated against her when she was 'in the final months of her residency'. The department chairman, nonetheless, was promoted to chairman of neurosurgery in July 2007, despite the three pending

lawsuits (Kowalczyk, 2007). In another case, three Indian Cardiologists accused hospital of racial discrimination in South Texas (Ramshaw, 2011).

SOCIAL DISTANCING AMONG THE FIRST AND THE SECOND-GENERATION INDIANS AT WORK

Additionally, I have delineated the context of social distancing at the workplace, which has created a paradoxical split due to discrimination of foreign-born Indian physicians by dominant groups and by their own ethnic counterparts who identify as second-generation in the interviews. The findings of this study indicate that the two generations of Indian physicians vary in perceptions and expectation of social behavior in the medical workplace. A number of second-generation Indian physicians in this research described the first-generation Indian physicians as wielding autocratic, racist, sexist and self-motivated attitudes at the work place. Some first-generation Indian physicians who followed strict teaching styles prevalent in India, trained second-generation Indians working under them much harder, exacerbating the workplace tensions between the two groups. Highlighting the contrast at workplaces in India and the United States, the second-generation physicians traced the autocratic attitudes displayed at work by first-generation Indians, to the hierarchical and stringent work culture prevalent in India.

On the other hand, a number of first-generation Indian physicians in my sample found the second-generation Indian physicians as discriminatory and

resentful of the presence of first-generation Indian physicians at the work place. Whereas some felt that second-generation physicians were harsher or more aggressive with them, others felt that they undervalued first-generation Indian physicians in terms of professionalism and technological skills. It was my subsequent round of interviews with the second-generation Indian physicians in the course of this study that finally enabled me to tease apart the tensions characterizing the interactions of first and second-generation Indian physicians. What was striking was the perception of some physicians that familial inter-generational tensions experienced at home resonated in professional interactions and tarnished the way second-generation physicians perceived their first-generation counterparts at work. These familial inter-generational tensions stem from the way in which the cultural and ethnic authenticity of Asian Americans is often questioned when they are labeled as not being 'Asian enough' in their conduct or their lifestyle (Tuan, 1999). Non-Asians perceive them to be closer to their own ethnic roots than to the American culture (Tuan, 1999). While foreign-born Asian immigrants belittle them as less than and watered down versions of themselves (Chen, 1992; Lee, 1996; Weiss, 1973a; Wong, 1977).

What was also important was how the racial stereotyping of second-generation Indians as 'model minorities' and the foreign medical graduate bias in the United States, colored and desensitized their perceptions of and interactions with first-generation Indian physicians who had done their medical schooling from India. Professional interactions between the two generations also soured due to

the ‘perceived threats’ and workplace ‘insecurities’ experienced by the second-generation Indian physicians against their first-generation counterparts. Sana aptly put it when she argued, “the people coming from India may feel a sense of insecurity, or sometimes people that are here [second-generation] feel a sense of entitlement and superiority that they are here,” which is ripe for conflict. However, it was interesting that caste played no role in the interactions between first and second-generation Indians or even among the second-generation who were mostly not aware of which caste they belonged to. However among physicians from India, caste did play some role only in terms of who they chose to interact with outside of work and with whom they chose to extend their professional interactions beyond the workplace.

Despite the social distancing between the two generations that I found in my research, there were exceptional cases like that of Mihir, a first-generation physician who has had extremely cordial, professionally helpful relationships with second-generation physicians at work. Although prior research shows that third-generation Asian ethnics with largely Asian-American friends profess to have a sense of kinship or special bond with them due to the perceived similarities’ based on ‘similar upbringing, parental expectations, values,’ resulting in ‘comfortable interactions’ that they may not experience with other non-Asians (Tuan, 1999:119-120). However this research shows that similar ethnicity, which brings together different versions of being an ‘Indian’, often ends up as a bone of contention between second-generation men and women in the United States.

GENDER DISCRIMINATION AND INDIAN WOMEN IN AMERICAN MEDICINE

Although research shows that women immigrate both as wives under the family reunification clause (Kofman, 1999) and as workers (Chang, 1997; Hardill and MacDonald, 2000; Ong and Azores, 1994), they remain relatively invisible in the scholarly literature on high skilled migration which is largely centered around men's experiences (Kofman, et al., 2000; Purkayastha, 2005b). A high skilled immigrant who arrived in the United States from India and became a part of the U.S. mainstream labor market was usually listed as male Asian Indian (Kanjanappan, 1995). His spouse who was highly qualified herself was 'rarely classified as highly skilled and was relegated to the undifferentiated category of ''wife''' (Purkayastha, 2005b:186). In my research I also examined the incidence and nature of gender based discrimination that immigrant women physicians and their second-generation counterparts faced in American medicine. I focused on three aspects: (1) gender discrimination against women physicians of Indian origin; (2) how does it interact with race; and (3) discrimination by patients along the lines of gender, race, and religion. Considering its ability to limit what they can accomplish in the United States, I documented the significant impact gender and race can have in molding the professional trajectories of Indian women physicians. Iredale (2000) argues that the kind of gate-keeping that women immigrants face is likely to be shaped by the national or international character of the profession that they seek to re-enter. My research found that gender combined with race served as a 'double hit' for Indian women physicians who

shoulder a double minority status at the workplace: gender and ethnic background. And the foreign medical graduate bias (ECFMG) in American medicine turned this status into a 'triple bind' for first-generation Indian women physicians. Research on Asian Indian women in the United States reports how Foreign medical degrees act as a 'major liability' enhancing the 'difficulty of ''breaking in''' even for women who have better access to networks of Indian physicians (Purkayastha, 2005b:188). These women also encounter "subtle forms of gender and race marginalization" (Purkayastha, 2005b:191).

Besides, race and gender hierarchies within immigration laws and at workplaces and households have negative effect on those women who attempt to reconstruct their careers (Purkayastha, 2005b). Being a good mother for most women of color, entails working for their families and financially providing for them (Stone, et al., 2006). However immigrant women because of their political status as dependants begin lives in new countries with relatively less power than their male counterparts. Work, home and political spheres act as a cumulative disadvantage against them (Purkayastha, 2005b). The result is that immigrant women who are also highly educated have to contend with more barriers than men in their capacity as wives and as immigrants in the U.S. labor market (Purkayastha, 2005b). In fact Purkayastha (2005b) in her study reveals that the master status of 'foreigners' persists for decades for several highly educated women who attempt to rebuild their lives within a series of racialized gender barriers. Research shows that despite controlling for individual level

characteristics, substantial differences in the earnings between Asian Indian women and white women persist (Stone, et al., 2006).

ASSIMILATION OF HIGH-STATUS IMMIGRANTS AND THE DILEMMA OF RETURN

Finally, the majority of the first-generation physicians interviewed for this study either did not want to return back to India, or were inclined not to. Return of immigrants 'is largely influenced by the initial motivations for migration as well as by the duration of the stay abroad and particularly by the conditions under which the return takes place' (Cassarino, 2004; Ghosh, 2000b:185). Some of the reasons the respondents advanced were the poor infrastructure, and the unethical, unorganized, and corrupt medical practice and work environment in India. Considering the impact of migration on development is largely contingent on the broader political and economic conditions at home, the leeway of targeted policies to 'improve' migration impacts are extremely restricted (Haas, et al., 2009). It is plausible that many 'temporary' high skilled migrants will become permanent settlers if economic and academic conditions in India remain negative.

But despite deciding not to return back to India in the immediate future, most of my research participants had not completely ruled out an opportunity to go back. While some cited their obligation and guilt towards their ageing parents who were left behind, the others missed the familiar social and cultural settings

back home. My findings also reveal how their dilemma of returning back to India vis-à-vis staying in the United States is affected to a large extent by the racial discrimination faced by them professionally and outside of work, and their own internal conflicts motivated by these. Ayaan who felt that the treatment of immigrants in the United States differed with the changing needs of the country retorted, “Whatever I do, whenever I go back to India, I always will be welcome there. Here it may not be the case. Times change…Arizona was a different place few months ago, now it’s an entirely different place.” Similarly first-generation Vivian asserted, “If you truly believe the claim that you are being treated differently or they are racist towards you, you are gonna be a third class citizen here, as opposed to a visa holder, for generations on, like the Irish, or the Jews, the Italians who came in. Still people look at them badly, and make fun of them. How many generations back did they come? So Asians are integrating, so we are even more recent along the scales. It does not help to be black or look different, very different facial features, being white helped the Irish and to all these guys. I think in my generation level I don’t see a benefit [of being a U.S. citizen]. Probably ten generations down, yes they probably integrate just fine and it will be great for them if they became a U.S. citizen…cause then probably equality might set in.”

TRANSNATIONALISM, SOCIAL INCORPORATION, AND HIGH-SKILLED IMMIGRANTS

Forces of transnationalism further enhance and shape the uncertainties of the Asian American community (Kibria, 1998). Roberts (1993:25-52) defines the 'transnational ethnic community' "as one whose culture and commitments are neither wholly oriented toward the new country nor to the old".[12] A number of immigrants today continue to cultivate robust transnational ties to more than one home country by forging and sustaining simultaneous multi-stranded social relations that link together their societies of origin and settlement. Their 'daily lives depend on multiple and constant interconnections across international borders' and their 'public identities are configured in relationship to more than one nation-state' (Schiller, et al., 1995:48). Transnational initiatives comprise a whole range of political, social and economic activities. The scope and frequency of transnational activities also increases if an immigrant community has greater access to time and space compressing technology (Alejandro Portes, et al., 1999). In addition, immigrant groups armed with greater average human capital and superior access to economic resources and infrastructure usually record greater levels of transnationalism (Alejandro Portes, et al., 1999).

Transnationalism with the social fields that it creates has transformed the relations of people to space by positioning and connecting actors in multiple countries (Castells, 1996; Vertovec, 1999). Unlike Appadurai (1995:213) who argues that new translocalities that emerge make it difficult for people to relate to

---

[1212] Roger Rouse, "Making sense of settlement: Class transformation, cultural struggle, and transnationalism among Mexican migrants in the United States." Annals of the New York Academy of Sciences, 645: 25-52 (1992).

or produce 'locality' ('as a structure of feeling, a property of life and an ideology of situated community'); Roberts (1993) shows that these identities actually enable immigrants to choose from a range of alternatives. Research on transnational migration attributes immigrants with decision making capabilities to affect their outcomes, as opposed to considering them as passive subjects who are subjugated by markets and compelled by the state (Roberts, Frank, and Lozano-Asencio, 1999; Smith, 1998). In fact transnational migration is conceived of as an alternative route that is opted by immigrants to counteract blocked opportunities in areas of origin and destination by combining what is beneficial in both the regions (Roberts, Frank, and Lozano-Ascencio, 1999).

The cultural resources that immigrant groups bring with them determine to a large extent the scope and character of transnational enterprise (Portes, 1999). The transnational character of their adaptive strategies are further fashioned by the extent of hostility and discrimination that they encounter (Portes, 1999). Research shows (Alba, 1990) that being an American continues to require European ancestry with Whites harboring a sense of 'proprietary claim' to being the authentic Americans (Blumer, 1958). This is also exemplified in how Asian-Americans continue to be situated outside the racial and cultural perimeters of the nation (Lowe, 1996). Transnational activities arm assimilating immigrant youths with a point of reference, what Bourne terms as the 'spiritual country' that enables them to ascertain their sense of self-worth that stems from their distinct identities (Portes, 1999). Cultural transnationalism also allows adult immigrants

to preserve their identities, language and customs by transmitting their valued traditions to their young (Gans, 1992; Zolberg, 1989). However these ongoing linkages may foster the resistance that Asian groups have against the U.S. systems of racial categorization and the racial identities of 'Asian' and 'Asian American.' Instead, these immigrants may rely more on the racial conceptions of their 'homeland' to comprehend their locations and their identities (Kibria, 1998).

Portes argues that it is in the second-generation that socio-cultural assimilation is most visible (Portes, 1999). With a large number of second-generation youths identifying themselves as hyphenated Americans their self-identification follows a similar course of change (Portes, 1999). This stems from the fact that Asian ethnics were considered outsiders (Tuan, 1999) as they did not match the image of a "real" American (Espiritu, 1992; Jiobu, 1988; Lowe, 1996; Nagel, 1994) and thereby strove to be recognized as authentic Americans with their rightful place in the United States (Espiritu, 1992; Kitano, 1992; Min, 1995; Takaki, 1987;1989; Wei, 1993). Unlike white ethnics, Asian ethnics irrespective of their generational status carry an assumption of 'foreignness' with them and do not have the option of discarding their ethnic links and merging with U.S. mainstream even after the first-generation (Tuan, 1999). Consequently, they also find their status in U.S. society subject to the changing political, social, and economic conditions that are beyond their control (Nishi, 1989). My research findings reflect that of Tuan (1999) in how first and second-generation Asians felt uncomfortable when they stopped at gift shops, gas stations, and other stores,

and frequently mentioned receiving poor service. In all of such incidents, they were made to feel that they did not belong where they were or were clearly out of place.

CONCLUSION

Bonilla-Silva argues that the United States is possibly the best example of the ideology of the Western world and its new racial practices, although it projects an international image of cosmopolitanism and openness like many other western nations (Bonilla-Silva, 2000;2002). Research shows (Bobo, et al., 1997; Bonilla-Silva and Lewis, 1999; Brooks, 1990; Smith, 1995) that the reproduction of racial inequality in the post-civil rights era occurs through racial practices that are largely informal, covert and institutional. These practices are unlike the formal exclusion and subordinate incorporation of racial minorities from the civil, political and economic life that was practiced in the past. This has led to the development of a new racial ideology, which has been labeled as 'laissez-faire racism or color-blind racism' to validate the contemporary racial status quo. Color-blind racists "avoid direct hostility toward minority groups and affirm the principles of equal opportunity and egalitarianism but at the same time reject programs that attempt to ameliorate racial inequality in reality rather than in theory" (Bonilla-Silva and Lewis, 1999:71). With the language of color blind racism being subtle, slippery and seemingly contradictory, Bonilla-Silva (2002) argues that liberal notions of opportunity and equality are often used to justify racial inequality. In fact Bonilla-Silva (2000) argues that in the post-civil rights

"color-blind" America, nativism mostly against immigrants of color is fast growing.

This research shows that even high-skilled immigrants of color and their second-generation counterparts build their identities against the backdrop of racial and gender based hierarchies that remain pervasive and regulate their social mobility and occupational structuring in the United States. Moreover, for physicians of Indian origin, social incorporation continues to be affected by the inter-dependency required in and outside of the medical workplace, and thus on occasion is affected by abuses, yielding differential results for the established members and the newcomers. Recognizing how socio-cultural biases about gender, race and sexuality color their interactions with each other and other ethnic groups will constitute the first step towards understanding the experiences of new immigrant groups, such as temporary H-1B and J-1 visa workers and second-generation Indians in the medical arena.

However, I did face a comparatively poor response rate from first-generation Indians vis-à-vis their second-generation counterparts for the interviews. Rachna, a first-generation physicians herself attributed this to how Indian physicians did not want to face the reality of racism. She argued, "I think they just don't want to face the reality because if you talk about this then you really view your experiences, and then if you talk then it's true, it becomes the truth….if you don't talk then it may never have happened…it's a kind of repression, you know repressing your bad memories so that's the only thing that

can make you go ahead." Conversely Naanak felt that "it's an issue of contribution to something bigger than you," and a "collaborative spirit" that first-generation Indians lacked as compared to the second-generation Indians. Either way, Indian physicians need to be much more forthcoming and engage in much needed critical research on the impact of emigration of physicians on India, and issues of racial and gender discrimination in the medical arena which impacts their assimilation in the United States. Moreover, this study reflects the need to recast the scholarly emphasis on race, gender and high-skilled migration by exploring the underlying prejudices behind race and gender identities that color the incorporation of immigrants and their second-generation counterparts yet are overshadowed by their 'rapid economic advancement'. Besides, considering the significant impact that health professionals can have in nourishing the Indian health sector, more research is required to understand the adverse long-term impact on India of such large-scale emigration of physicians, and how their return can be facilitated and better sustained.

REFERENCES

Aboud, F. E. (1977). Interest in Ethnic In- formation: A Cross-Cultural Developmental Study. *Canadian Journal of Behavioral Science, 9*.

Acker, J. (1990). Hierarchies, Jobs, Bodies: A Theory of Gendered Organizations. *Gender and Society, 4*(2), 143.

Acker, J. (1992). Gendered institutions: From sex roles to gendered institutions. *Contemporary Sociology, 21*, 565.

Acker, J. (2006). Inequality regimes: Gender, class, and race in organizations. *Gender & Society, 20(4)*, 441.

Adkoli, B. V. (2006). Migration of Health Workers: Perspectives from Bangladesh, India, Nepal, Pakistan and Sri Lanka. *Regional Health Forum 10*(1).

Ahmed, L. N. (1957). Indian Students in America and Acceptance of Americans. *The Journal of Negro Education, 26*(1), 59.

AIIMS. (2011). ADVERTISEMENT NO.01/2011(FC). Retrieved September 30, 2012, from http://www.aiims.edu/aiims/events/recruitment/finaladvertisement.pdf

Alarcon, R. (1999). Recruitment processes among foreign-born engineers and scientists in Silicon Valley. *American Behavioral Scientist, 42*(9).

Alba, R. (1990). *Ethnic identity: The transformation of white America*. New Haven,CT: Yale University Press.

Alba, R., and Nee, V. (1997). Rethinking Assimilation Theory for a New Era of Immigration. *International Migration Review, 31*(4), 826.

Alba, R., and Nee, V. (2003). *Remaking the American Mainstream: Assimilation and Contemporary Immigration*. Cambridge, Mass: Harvard University Press.

Alba, R., and Waters, M. C. (Eds.). (2010). *The Next Generation: The Children of Immigrants in Europe and North America*. New York: New York University Press.

Alejandro Portes, Luis E. Guarnizo, and Landolt, P. (1999). The study of transnationalism: pitfalls and promise of an emergent research field. *Ethnic and Racial Studies, 22*(2).

Allen, I. (2000). The handling of complaints by the GMC. A study of decision-making and outcomes. *London: PSI*.

Ananthakrishnan, N. (2007). Acute shortage of teachers in medical colleges: Existing problems and possible solutions. *Natl Med J India, 20*(1), 25.

Anwar, M., and Ali, A. (1987). Overseas Doctors: Experience and Expectations. *London: CRE*.

Appadurai, A. (Ed.). (1995). *The production of locality*. London: Routledge.

Arlow, F. L., Raymond, P. L., Karlstadt, R. G., Croitoru, R., Rybicki, B. A., and Sastri, S. V. (2002). Gastroenterology training and career choices: a prospective longitudinal study of the impact of gender and of managed care. *Am J Gastroenterol, 97*(2), 459.

Ash, A. S., Carr, P. L., Goldstein, R., and Friedman, R. H. (2004). Compensation and advancement of women in academic medicine: is there equity? *Ann Intern Med, 141*(3), 205.

Atre Vaidya, N. (2006). Women chairs in psychiatry: a collective reflection. *Acad Psychiatry, 30*(4), 315.

Ausdale, D. V., and Feagin, J. R. (1996). Using Racial and Ethnic Concepts: The Critical Case of Very Young Children. *American Sociological Review, 61*(5), 779.

Bach, R. L. (1993). Recrafting the Common Good. *Annals of the American Academy of Political and Social Science, 530*.

Baldwin, D. C., Jr., Daugherty, S. R., and Eckenfels, E. J. (1991). Student perceptions of mistreatment and harassment during medical school. A survey of ten United States schools. *West J Med, 155*(2), 140.

Balon, R., Mufti, R., Williams, M., and Riba, M. (1997). Possible discrimination in recruitment of psychiatry residents? *Am J Psychiatry, 154*(11), 1608.

Barrera, M. (1979). *Race and Class in the Southwest: A Theory of Racial Inequality*. Notre Dame, IN: University of Notre Dame Press.

Barringer, H., and Kassebaum, G. (1989). Asian Indians as a Minority in the United States: The Effect of Education, Occupations and Gender on Income. *Sociological Perspectives, 32*(4), 501.

Barth, F. (1969). *Ethnic groups and boundaries: the social organization of culture difference*: Little, Brown.

Bass, B., Avolio, B., and Atwater, L. (1996). The transformational and transactional leadership of men and women. *Applied Psychology: An International Review, 45*, 5.

Benard, S., and Correll, S. J. (2010). NORMATIVE DISCRIMINATION AND THE MOTHERHOOD PENALTY. *Gender & Society, 24: 616*.

Bendl, R., and Schmidt, A. (2010). From 'Glass Ceilings' to 'Firewalls'— Different Metaphors for Describing Discrimination. *Gender, Work & Organization, 17*(5), 612.

Benedict, R. F. (1945). *Race and Racism*. London, England: Routledge and Kegan Paul.

Berger, J., Cohen, B. P., and Zelditch, M., Jr. (1972). Status Characteristics and Social Interaction. *American Sociological Review, 37*(3), 241.

Bhatia, S. (2008). 9/11 and the Indian Diaspora: Narratives of Race, Place and Immigrant Identity. [doi:10.1080/07256860701759923]. *Journal of Intercultural Studies, 29*, 21.

Bhattacharya, G. (2008). The Indian Diaspora in Transnational Context: Social Relations and Cultural Identities of Immigrants to New York City. [doi:10.1080/07256860701759949]. *Journal of Intercultural Studies, 29*, 65.

Bhattacharya, G., and Schoppelrey, S. (2004). Pre-immigration Beliefs of Life Success, Post-immigration Experiences, and Acculturative Stress: South Asian Immigrants in the U.S. *Journal of*

Immigrant Health, 6(2), 83.

Bickel, J., Wara, D., Atkinson, B. F., Cohen, L. S., Dunn, M., Hostler, S., et al. (2002). Increasing women's leadership in academic medicine: report of the AAMC Project Implementation Committee. *Acad Med, 77*(10), 1043.

Biernacki, P., and Waldorf, D. (1991). Snowball sampling: Problems and techniques of chair referral sampling. *Sociological Methods and Research, 10*, 141.

Blauner, R. (1972). *Racial Oppression in America*. New York: Harper and Row.

Blumer, H. (1958). Race Prejudice as a Sense of Group Position. *The Pacific Sociological Review, 1*(1), 3.

Blumer, H. (1969). *Symbolic interactionism*. Berkeley: University of California Press.

Bobo, L., Kluegel, J., and Smith, R. A. (Eds.). (1997). *Laissez-Faire Racism: The Crystallization of a Kinder, Gentler, Anti Black Ideology.* Westport, CN: Praeger.

Bodnar, J. (1987). The transplanted: A history of immigrants in urban America. *Bloomington: Indiana University Press*.

Bogardus, E. S. (1925). Measuring Social Distances. *Journal of Applied Sociology, 9*, 299.

Bonilla-Silva, E. (1997). Rethinking Racism: Toward a Structural Interpretation. *American Sociological Review, 62*(3), 465.

Bonilla-Silva, E. (2000). “This is a White Country”: The Racial Ideology of the Western Nations of the World-System. *sociological Inquiry, 70*(2).

Bonilla-Silva, E. (2002). The Linguistics of Color Blind Racism: How to Talk Nasty about Blacks without Sounding “Racist”. *Critical Sociology, 28*(1-2).

Bonilla-Silva, E., and Lewis, A. (1997). *The 'New Racism': Toward an Analysis of the U.S. Racial Structure, 1960s-1990s*.Unpublished manuscript.

Bonilla-Silva, E., and Lewis, A. E. (Eds.). (1999). *The New Racism: Toward an Analysis of the U.S. Racial Structure, 1960s-1990s*. Boulder, CO: Westview Press.

Borjas, G. (1989). Economic theory and international migration. *International Migration Review, 23*(3).

Borjas, G. (1990). *Friends or Strangers, the Impact of Immigrants on the US Economy*. New York: Basic Books.

Brettell, C. B. (2005). The Spatial, Social And Political Incorporation Of Asian Indian Immigrants In Dallas, Texas *Urban Anthropology And Studies Of Cultural Systems And World Economic Development, 34*(2/3).

Brettell, C. B., and Reed-Danahay, D. (2012). *Civic Engagements: The Citizenship Practices of Indian & Vietnamese Immigrants*: Stanford University Press.

Bright, C. M., Duefield, C. A., and Stone, V. E. (1998). PERCEIVED BARRIERS AND BIASES IN THE MEDICAL EDUCATION EXPERIENCE BY GENDER AND RACE. *JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, 90*(1).

Britton, D. M. (2000). The Epistemology of the Gendered Organization. *Gender and Society, 14*(3), 418.

Brooks, R. (1990). *Rethinking the American Race Problem*. Berkeley: University of California Press.

Brotherton, S. E., and Etzel, S. I. (2010). Graduate Medical Education, 2009-2010 *JAMA, 304*(11).

Budig, M., and England, P. (2001). The wage penalty for motherhood. *American Sociological Review, 66*, 204.

Burgess, D., and Borgida, E. (1999). Who women are, who women should be: Descriptive and prescriptive stereotyping in gender discrimination. *Psychology,*

Public Policy and Law, 5, 665.

Carmichael, S. (1971). *Stokely Speaks: Black Power Back to Pan-Africanism*. New York: Vintage Books.

Carnes, M., Morrissey, C., and Geller, S. E. (2008). Women's health and women's leadership in academic medicine: hitting the same glass ceiling? *J Womens Health (Larchmt), 17*(9).

Carr, P. L., Ash, A. S., Friedman, R. H., Scaramucci, A., Barnett, R. C., Szalacha, L., et al. (1998). Relation of family responsibilities and gender to the productivity and career satisfaction of medical faculty. *Ann Intern Med, 129*(7), 532.

Carr, P. L., Ash, A. S., Friedman, R. H., Szalacha, L., Barnett, R. C., Palepu, A., et al. (2000). Faculty perceptions of gender discrimination and sexual harassment in academic medicine. *Ann Intern Med, 132*(11), 889.

Carr, P. L., Palepu, A., Szalacha, L., Caswell, C., and Inui, T. (2007). 'Flying below the radar': a qualitative study of minority experience and

management of discrimination in academic medicine. *Medical Education, 41*, 601.

Carr, P. L., Szalacha, L., Barnett, R., Caswell, C., and Inui, T. (2003). A "ton of feathers": gender discrimination in academic medical careers and how to manage it. *J Womens Health (Larchmt), 12*(10), 1009.

Cassarino, J. (2004). Theorising Return Migration: The Conceptual Approach to Return Migrants Revisited. *International Journal on Multicultural Societies 6*(2), 253.

Castells, M. (1996). *The Rise of the Network Society*. Oxford: Blackwell.

Castles, S. (2004). The factors that make and unmake migration policies. *International Migration Review, 38*(3), 852.

Chacko, E. (2007). From brain drain to brain gain: reverse migration to Bangalore and Hyderabad, India's globalizing high tech cities. *GeoJournal, 68*, 131.

Chandrasekhar, S. (1944). Indian Immigration in America. *Far Eastern Survey, 13*(15), 138.

Chandrasekhar, S. (1982). *From India to America: A Brief History of Immigration: Problems of Discrimination, Admission and Assimilation*. La Jolla, California: Population Review Publications.

Chang, G. (Ed.). (1997). *The global trade in Filipina workers*. South End Press: Boston.

Chatterjee, P. (April 04, 2011). Months after nod, AIIMS faculty posts lie vacant. Retrieved September 30, 2012, from

http://www.indianexpress.com/news/months-after-nod-aiims-faculty-posts-lie-vacant/771264/0

Chen, H. (1992). *Chinatown No More*. New York: Cornell University Press.

Chen, P. G., Nunez-Smith, M., Bernheim, S. M., Berg, D., Gozu, A., and Curry, L. A. (2010). Professional experiences of international medical graduates practicing primary care in the United States. *J Gen Intern Med, 25*(9), 947.

Chinai, R., and Goswami, R. (March 2007). Medical visas mark growth of Indian medical tourism*. Bulletin of the World Health Organization*.

Clark, K. B., and Clark, M. P. (1939). The Development of Consciousness of Self and the Emergence of Racial Identification in Negro Preschool Children. *Journal of Social Psychology, SPSSI Bulletin, 10*, 591.

Clemens, M. A. (2009). Skill Flow: A Fundamental Reconsideration of Skilled-Worker Mobility and Development. *Human Development Research Paper, UNDP Human Development Reports*, 8.

CMS. (April 11, 2012). National Health Expenditure Projections 2010-2020. Retrieved September 30, 2012, from http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/proj2010.pdf

Cockburn, C. (1983). *Brothers: Male dominance and technological change*. London: Pluto.

Cockburn, C. (1985). *Machinery of dominance: Women, men and technical know-how*. London: Pluto.

Coker, N. (2001). 'Understanding race and racism' in N. Coker (ed.) Racism in Medicine. *London: King's Fund*.

Cook, D. J., Liutkus, J. F., Risdon, C. L., Griffith, L. E., Guyatt, G. H., and Walter, S. D. (1996). Residents' experiences of abuse, discrimination and sexual harassment during residency training. McMaster University Residency Training Programs. *CMAJ, 154*(11), 1657.

Cooke, L., Halford, S., and Leonard, P. (2003). Racism in the medical profession: the experience of UK graduates. *London: BMA*.

Coombs, A., and King, R. (2005). Workplace discrimination: experiences of practicing physicians. *J Natl Med Assoc, 97*(4), 467.

Cox, O. C. (1948). *Caste, Class, and Race*. New York: Doubleday.

Danielewicz, J. M., Rogers, D. L., and Noblit, G. (1996). Children's Discourse Patterns and Power Relations in Teacher-Led and Child-Led Sharing Time. *Qualitative Studies in Education, 9*, 311.

Datta, K. K. (2009). *Public Health Workforce In India: Career Pathways For Public Health Personnel*.

DCRI. (August 31, 2011). Best-in-class partners: Duke Medicine and Medanta-The Medicity. Retrieved September 30, 2012, from https://dcri.org/research/videos/best-in-class-partners-duke-medicine-and-medanta-the-medicity

Devadasan, N., Ranson, K., Van Damme, W., Acharya, A., and Criel, B. (2006). The landscape of community health insurance in India: an overview based on 10 case studies. *Health Policy, 78*(2-3), 224.

Dhingra, P. (2007). *Managing Multicultural Lives: Asian American Professionals and the Challenge of Multiple Identities*. Palo Alto, CA: Stanford University Press.

Dhingra, P. (2008). Committed to Ethnicity, Committed to America: How Second-Generation Indian Americans' Ethnic Boundaries Further their Americanisation. [doi:10.1080/07256860701759931]. *Journal of Intercultural Studies, 29*, 41.

Dhingra, P. (2010). Hospitable to others: Indian American motel owners create boundaries and belonging in the heartland. *Ethnic and Racial Studies, 33*(6), 1088

Dobson, R. (1997). Women doctors believe medicine is male dominated. *BMJ, 315*(7100), 80.

Dresler, C. M., Padgett, D. L., MacKinnon, S. E., and Patterson, G. A. (1996). Experiences of women in cardiothoracic surgery. A gender comparison. *Arch Surg, 131*(11), 1128.

Dublin, T. D. (1972). The Migration of Physicians to the United States. *The New England Journal of Medicine, 286*(16), 870.

Duncan, G. (2008). When to Promote and When to Avoid, a Population Perspective. *Demography, 45*, 763.

Dustmann, C. (1996). The social assimilation of immigrants. *J Popul Econ, 9*(1), 37.

Dyer, C. (1997). GMC accused of prejudicing doctors' defence. *BMJ, 315*(7117), 1177.

Eagly, A. H., Johannesen-Schmidt, M. C., and van Engen, M. L. (2003). Transformational, transactional, and laissez-faire leadership styles: a meta-analysis comparing women and men. *Psychol Bull, 129*(4), 569.

Eagly, A. H., and Karau, S. J. (2002). Role congruity theory of prejudice toward female leaders. *Psychological Review, 109*, 573.

Eaton, L. (2006, 22 April). Tossed aside. *BMJ, 332*.

Ebell, M. H. (2008). Future Salary and US Residency Fill Rate Revisited. *JAMA, 300*(10).

ECFMG. (June 4, 2012). 2011 Annual Report. Retrieved Septermber 30, 2012, from http://www.ecfmg.org/resources/ECFMG-2010-annual-report.pdf

Economist, T. (2001, May 31st). A survey of India's economy: A management guide

How to run India Inc.

Ellis, R. P., Alam, M., and Gupta, I. (2000). Health Insurance in India: Prognosis and Prospectus. *Economic and Political Weekly, 35*(4), 207.

ElsevierExamZone. (2012). Post Graduate Medical Entrance Examination. Retrieved April 25, 2012, from http://www.elsevier-examzone.com/About-PGMEE.aspx?pageid=gN00T93ZWjw%3D

Esmail, A., Abel, P., and Everington, S. (2003). Discrimination in the discretionary points award scheme: comparison of white with non-white consultants and men with women. *BMJ, 326*(7391), 687.

Esmail, A., and Everington, S. (1993). Racial discrimination against doctors from ethnic minorities. *BMJ, 306*(6879), 691.

Esmail, A., Everington, S., and Doyle, H. (1998). Racial discrimination in the allocation of distinction awards: Analysis of list of award holders by type of award, specialty and region. *BMJ*, 316.

Espiritu, Y. (1992). *Asian-American Panethnicity*. Philadelphia: Temple University Press.

Espiritu, Y. (1997). *Asian American Women and Men: Love, Labor, Laws*. CA: Thousand Oaks, Sage.

Esterberg, K. (2002). *Qualitative methods in social research*. New York: McGraw-Hill.

Everington, S. (2004). *Challenges facing ethnic minority doctors in the NHS* Paper presented at the BAPIO National Conference - Challenges and Opportunities in the Modern National Health Service.

Fang, D., May, E., Colburn, L., and Hurley, J. (2000). Racial and ethnic disparities in faculty promotion in academic medicine. Fang D, moy E,*(1) colburn L, hurley J. JAMA 2000;284:1085-1092. *Am J Ophthalmol, 130*(6), 863.

Feagin, J. R. (1991). The Continuing Significance of Race: Antiblack Discrimination in Public Places. *American Sociological Review, 56*(1), 101.

Feagin, J. R., and Eckberg, D. L. (1980). Discrimination: Motivation, Action, Effects, and Context. *Annual Review of Sociology, 6*(ArticleType: primary_article / Full publication date: 1980 / Copyright © 1980 Annual Reviews), 1.

Feagin, J. R., and Sikes, M. P. (1994). *Living With Racism: The Black Middle Class Experience*. Boston: Beacon Press.

FinanceWire. (2006, July).

Firth-Cozens, J. (1990). Source of stress in women junior house officers. *BMJ, 301*(6743), 89.

Fisher, M. (1980). *The Indians of New York City*. New Delhi: Heritage Publishers.

Fong, T. (1998a). *The Contemporary Asian American Experience*. Upper Saddle River, NJ: Prentice Hall.

Fong, T. (1998b). *The Contemporary Asian American Experience: Beyond the Model Minority*. Upper Saddle Ridge: Prentice-Hall.

Fox, L. (2006). Silence speaks loud on immigration rule. *Hospital doctor, 27 April: 2*.

Frank, A. G. (1967). *Capitalism and Underdevelopment in Latin America*. New York: Monthly Review Press.

Frank, E., Brogan, D., and Schiffman, M. (1998). Prevalence and correlates of harassment among US women physicians. *Arch Intern Med, 158*(4), 352.

Frieden, J. (1996). IMGs boost psychiatry match rate again. *Clin Psychiatry News, 1–2*.

Gans, H. (1979). Symbolic ethnicity: The future of ethnic groups and cultures in America. *Ethnic and Racial Studies, 2*(1), 1.

Gans, H. (1992). Second-generation decline: scenarios for the economic and ethnic futures of the post-1965 American immigrants. *Ethnic and Racial Studies, 15*(2).

Garg, A. (2007). Racism at work : inter-spouse stress and strain transfer. *In: Triennial WES Conference: Beyond these shores, sinking or swimming in the globalised economy, 12-14 Sept 2007, Aberdeen University. (Unpublished)*.

Ghosh, B. (2000a). Return migration: reshaping policy approaches. In B. Ghosh (Ed.), *Return Migration: Journey of Hope or Despair?* (pp. 181). Geneva: International Organization for Migration.

Ghosh, B. (Ed.). (2000b). *Introduction: towards a new international regime for orderly movements of people*. Oxford: Oxford University Press.

Glaser, W. A., and Habers, G. C. (1974). The Migration and Return of Professionals. *International Migration Review, 8*(2), 227.

Gmelch, G. (1980). Return Migration. *Annual Review of Anthropology, 9*, 135.

Gordon, M. (1964). *Assimilation in American Life*. New York: Oxford University Press.

Gordon, M. M. (1961). Assimilation in America: Theory and Reality. *Daedalus, 90*(2), 263.

Gray, G. M., Gallagher, T. C., and Masters, M. S. (1996). Contrasting experiences and perceptions of women and men physician graduates of Stanford University School of Medicine. *Trans Am Clin Climatol Assoc, 107*, 159.

Gruber, J. (2010). The cost implications of health care reform. *N Engl J Med, 362*(22), 2050.

Gupta, M. D. (1997). "What Is Indian about You?": A Gendered, Transnational Approach to Ethnicity. *Gender and Society, 11*(5), 572.

Haas, H. d., Bakewell, O., Castles, S., Jónsson, G., and Vezzoli, S. (2009). *Mobility and Human Development*.

Hacker, S. (1990). *"Doing it the hard way": Investigations of gender and technology*. Boston: Unwin Hyman.

Hadley, J., Cantor, J. C., Willke, R. J., Feder, J., and Cohen, A. B. (1992). Young physicians most and least likely to have second thoughts about a career in medicine. *Acad Med, 67*(3), 180.

Halperin, T. J., Werler, M. M., and Mulliken, J. B. (2010). Gender Differences in the Professional and Private Lives of Plastic Surgeons

. *Annals of Plastic Surgery, 64(6)*.

Handlin, O. (1951). *The Uprooted*. Boston: Little, Brown.

Hardill, I., and MacDonald, S. (2000). Skilled international migration: the experience of nurses in the UK. *Regional Studies 37*.

Harris, N. (1995). The New Untouchables: Immigration and the New World Worker. *Penguin Books*.

Harrison, F. V. (1998). Introduction: Expanding the Discourse on "Race". *American Anthropologist, 100*(3), 609.

Hatala, R. (2003). Medical women in academia: silenced by the system. *CMAJ, 168*(5), 542.

Health, V. D. o. (Producer). (2011) J-1 Visa Waiver Program Overview. retrieved from http://www.vdh.state.va.us

Healthcaresalaryonline. (2012). Internist Salary. Retrieved April 25, 2012, from http://www.healthcaresalaryonline.com/internist-salary.html

Heath, I. (2004). Women in medicine. *BMJ, 329*(7463), 412.

Heilman, M. E. (2001). Description and prescription: How gender stereotypes prevent women's ascent up the organizational ladder. *Journal of Social Issues, 57*, 657.

Heilman, M. E., Block, C. J., and Martell, R. F. (1995). Sex stereotypes: Do they influence perceptions of managers? *Journalof Social Behaviorand Personality, 10*.

Heilman, M. E., Wallen, A. S., Fuchs, D., and Tamkins, M. M. (2004). Penalties for success: Reactions to women who succeed at male gender- typed tasks. *Journal of Applied Psychology, 89*, 416.

Heller, A. (1990). General Ethics. *Oxford: Basil Blackwell*.

Helweg, A. (1997). Why Leave India for America? A Case Study Approach to Understanding Migrant Behavior. *International Migration, 25*(2), 165.

Herald, D. (2008). http://www.deccanherald.com.

Herrick, D. M. (November 2007). *Medical Tourism: Global Competition in Health Care* (No. 304): National Center for Policy Analysis (Dallas, Texas) Report No. 304.

Hess, G. (1974). The Forgotten Asian Americans: The East Indian Community in the United States. *Pacific Historical Review, 43*, 577.

Iredale, R. (2000). Migration policies for the highly skilled in the Asia-Pacific region. *International Migration Review, 34*(3).

Janesick, V. J. (1994). *The Dance of Qualitative Research Design: Metaphor, methodolatry, and meaning*. Thousand Oaks London: Sage.

Jeffery, R. (1976). Migration of Doctors from India. *Economic and Political Weekly, 11*(13), 502.

Jensen, J. M. (I988). *Passage from India: Asian Indian Immigrants in North America*. New Haven, CT: Yale University Press.

Jiobu, R. (1988). *Ethnicity and Assimilation: Blacks, Chinese, Filipinos, Japanese, Koreans, Mexicans, Vietnamese,and Whites*. New York: State University of New York Press.

Johnson, A., and Evans, K. (April 13, 2009). Recession Now Hits Jobs in Health Care. Retrieved September 30, 2012, from http://online.wsj.com/article/SB123958719598112571.html

Justice, U. S. D. o. (1970). *Annual Report of the Immigration and Naturalization Service*.

Kanjanappan, W. (1995). Immigration of Asian Professionals to the US 1988–1990. *International Migration Review, 29*.

Kanter, R. M. (1975). *Women and the structure of organizations: Explorations in theory and behavior*. New York: Doubleday.

Kar, S., Campbell, K., Jimenez, A., and Gupta, S. R. (1996). Invisible Americans: An exploration of Indo-American quality of life. *Amerasia Journal, 21*(3), 25.

Kasinitz, P., Mollenkopf, J. H., Waters, M. C., and Holdaway, J. (2008). *Inheriting the City: The Children of Immigrants Come of Age*. New York: Russell Sage Foundation.

Kass, R. B., Souba, W. W., and Thorndyke, L. E. (2006). Challenges confronting female surgical leaders: overcoming the barriers. *J Surg Res, 132*(2).

Kaushik, M., Jaiswal, A., Shah, N., and Mahal, A. (2008). High-end physician migration from India. *Bull World Health Organ, 86*(1), 40.

Khadria, B. (1990). Migration of Human Capital to United States. *Economic and Political Weekly*.

Khadria, B. (2004). *Migration of Highly Skilled Indians: Case Studies of IT and the Health Professionals*.

Kibria, N. (1998). The contested meanings of Asian American: racial dilemmas in the contemporary US. *Ethnic and Racial Studies, 21*(5).

Kibria, N. (2002). *Becoming Asian American: Second Generation Chinese and Korean American Identities*. Baltimore, MD: Johns Hopkins University Press.

Kim, C., and Sakamoto, A. (2010). Have Asian American Men Achieved Labor Market Parity with White Men? *American Sociological Review, 75*(6), 934.

King, R. (1978). Return migration: a neglected aspect of population geography. *Area, 10*(3), 175.

Kitano, H. (1992). *Generations and Identity: The Japanese-American*. Massachusetts: Ginn Press.

Kitano, H. H. L., and Daniels, R. (1998). *Asian Americans: Emerging Minorities*. Englewood Cliffs, NJ: Prentice Hall.

Kofman, E. (1999). Female 'birds of passage' a decade later: gender and immigration in European union. *International Migration Review, 33*.

Kofman, E., Phizacklea, A., Raghuram, P., and Sales, R. (2000). *Gender and International Migration in Europe: Employment, Welfare and Politics*. London: Routledge.

Konana, P. (2006). The healthcare tourism conundrum*. The Hindu*

Koritala, S. B. A historical perspective of Americans of Asian Indian origin 1790-1997 Retrieved Aug 6, 2011, from http://www.infinityfoundation.com/mandala/h_es/h_es_korit_histical.htm

Kowalczyk, L. (2007, December 30, 2007). Women surgeons complain of bias by male chief*. The Boston Globe*.

Kumar, P., and TB, S. (2007). *Barriers to Movement of Health Professionals: A Case Study of India*. New Delhi: Prepared for the WTO Cell, Ministry of Health and Family Welfare, Government of India and WHO India Country Office.

Kurien, P. (2001). Religion, ethnicity and politics: Hindu and Muslim Indian immigrants in the United States. *Ethnic and Racial Studies, 24*(2), 263

Lamphere, L. (1992). *Structuring Diversity: Ethnographic Perspec- tives on the New Immigration.* . Chicago: **University of Chicago Press**.

Lee, J. (2005). WHO WE ARE: America Becoming and Becoming American. *Du Bois Review, 2*, 287.

Lee, S. (1996). *Unraveling the "Model Minority" Stereotype: Listening to Asian-American Youth*. New York: Teachers College Press.

Lerner, B. H. (2006, March 14). Young Doctors Learn Quickly in the Hot Seat. *The New York Times*. Retrieved from http://www.nytimes.com/2006/03/14/health/14comm.html

Lieberson, S. (1985). Unhyphenated Whites in the United States. *Ethnic and Racial Studies, 8*, 159.

Lieberson, S., and Waters, M. (1993). The Ethnic Responses of Whites: What Causes Their Instability, Simplification, and Inconsistency? *Social Forces, 72*, 421.

Liebschutz, J. M., Darko, G., Finley, E. P., Cawse, J. M., Bharel, M., and Orlander, J. D. (2006). In the Minority: Black Physicians in Residency and Their Experiences. *JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION, 98*(9).

Llandudno, Z. K. (2004). Doctors' careers are blighted by discrimination, says BMA. *BMJ , 329*.

Lohr, K., Vanelow, N. A., Detmer, D., and eds. (1996). *The nation's physician workforce: options for balancing supply and requirements*.

Lowe, L. (1996). *Immigrant Acts*: Duke University Press.

Lyman, S. (1973). *The Black American in Sociological Thought: A Failure of Perspective*. New York: Capricorn.

MacLeod, K. (1996). Isolation, excessive time demands and sexism face female MDs, CMA workshop told. *CMAJ, 154*(5), 708.

Maira, S. (2004). *Imperial Feelings: Youth Culture, Citizenship, and Globalization*. Berkeley: University of California Press.

Matas, D. (1994). Racism and Migration. *Refuge, 13*(8).

Mazure, C. M., Arons, A., and Vitali, A. (2001). Examining structured representation and designated fiscal support for women's health in the U.S. Department of Health and Human Resources. *J Womens Health Gend Based Med, 10*(9), 849.

McClain, L. (1986). The Insidious New Racism. In C. Page (Ed.), *A Foot in Each World* (pp. 20). Evanston Ill.: Northwestern University Press.

MCI. (2012a). List of Colleges Teaching MBBS. Retrieved September 30, 2012, from http://www.mciindia.org/InformationDesk/MedicalCollegeHospitals/ListofCollegesTeachingMBBS.aspx

MCI. (2012b). List Of Colleges Teaching PG Courses. Retrieved September 30, 2012, from http://www.mciindia.org/InformationDesk/ForStudents/ListofCollegesTeachingPGCourses.aspx

MCI. (2012c). Post Graduate Medical Education Regulations 2000 (Amended upto March 2012). Retrieved September 30, 2012, from http://www.mciindia.org/RulesandRegulations/PGMedicalEducationRegulations2000.aspx

MDACC. (2012). Global Map of Institutions. Retrieved September 30, 2012, from http://www.mdanderson.org/education-and-research/education-and-

training/schools-and-programs/global-academic-programs/sister-institutions/index.html

Melville, M. (Ed.). (1980). *Twice A Minority-Mexican American Women*. St. Louis: C.V. Mosby.

Milstein, A., and Smith, M. (2006). America's new refugees--seeking affordable surgery offshore. *N Engl J Med, 355*(16), 1637.

Min, P. (Ed.). (1995). *Asian-Americans*. Thousand Oaks: Sage Publications.

Min, P. G., and Kim, Y. O. (2009). Ethnic and sub-ethnic attachments among Chinese, Korean, and Indian immigrants in New York City. *Ethnic and Racial Studies, 32*(5), 758

Minocha, U. (1987). *South Asian Immigrants. Trends and Impact on the Sending and Receiving Societies*. New York: Centre for Migration Studies.

Mohan, R. (2008). Growth Record of the Indian Economy, 1950-2008: A Story of Sustained Savings and Investment. *Economic & Political Weekly*, 61.

Moore, J. W. (1970). Colonialism:The Case of the Mexican-Americans. *Social Problems 17*.

Mudur, G. (2001). Auditors slate top Indian medical centre. *BMJ, 323*(7312), 530.

Mullan, F. (2005). The metrics of the physician brain drain. *N Engl J Med, 353*(17), 1810.

Mullan, F. (2006). Doctors for the world: Indian physician emigration. *Health Aff (Millwood), 25*(2), 380.

Muraleedharan, V. R., and Nandraj, S. (2003). *Private health care sector in India: policy challenges and options for partnership. In: Yazbeck AS, Peters DH,*

eds. Health Policy Research in South Asia: Building Capacity for Reform. Washington, DC: World Bank Publications; 2003: 229-256

.

Murphy, S. (2004, September 25, 2004). Doctor's suit says residency marred by ethnic bias: Harvard professor cites VA hospital. *The Boston Globe*.

Nagel, J. (1994). Constructing ethnicity: Creating and recreating ethnic identity and culture. *Social Problems, 41*.

Nagral, S. (2011). Ethics, equity and justice: a view from the belly of the beast. *Indian J Med Ethics, 8*(1), 9.

Naples, N. (2003). *Feminism and Method*: Taylor and Frances.

Narasimhan, V., Brown, H., and al, e. (2004). Responding to the global human resources crisis. *Lancet, 363*, 1469.

Narayan, R. (2011). Universal health care in India: missing core determinants. *The Lancet, 377*.

Nasir, L. S. (1994). Evidence of discrimination against international medical graduates applying to family practice residency programs. *Fam Med, 26*(10), 625.

Neidert, L., and Farley, R. (1985). Assimilation in the United States: An Analysis of Ethnic and Generation Differences in Status and Achievement. *American Sociological Review, 50*, 840.

Nishi, S. (Ed.). (1989). *Perceptions and deceptions: Contemporary views of Asian-Americans*. New York: Minority Rights Group, Inc.

Nunez-Smith, M., Pilgrim, N., Wynia, M., Desai, M. M., Jones, B. A., Bright, C., et al. (2009). Race/ethnicity and workplace discrimination: results of a national survey of physicians. *J Gen Intern Med, 24*(11), 1198.

Ong, P., and Azores, T. (Eds.). (1994). *The migration and incorporation of Filipino nurses*. Philadelphia: Temple University Press.

Palepu, A., Carr, P. L., Friedman, R. H., Amos, H., Ash, A. S., and Moskowitz, M. A. (1998). Minority faculty and academic rank in medicine. *JAMA, 280*(9), 767.

Palepu, A., Carr, P. L., Friedman, R. H., Ash, A. S., and Moskowitz, M. A. (2000). Specialty choices, compensation, and career satisfaction of underrepresented minority faculty in academic medicine. *Acad Med, 75*(2), 157.

Palepu, A., and Herbert, C. P. (2002). Medical women in academia: the silences we keep. *CMAJ, 167*(8), 877.

Park, R. (1950). *Race and Culture*. Glencoe: The Free Press.

Park, R. (Ed.). (1930). *Assimilation, Social*. New York: Macmillan.

Park, R., and Burgess, E. (1969). *Introduction to the Science of Sociology. 1921. Reprint*. Chicago: University of Chicago Press.

Park, R. E. (1914). Racial Assimilation in Secondary Groups With Particular Reference to the Negro. *The American Journal of Sociology, 19*(5), 606.

Perlo, V. (1975). *Economics of Racism U.S.A.: Roots of Black Inequality*. New York: International Publishers.

Petersdorf, R., Turner, K., Nickens, H., and Ready, T. (1989). Minorities in medicine: past, present, and future. *Acad Med, 65*, 663.

Petersdorf, R. G. (1994). It's report card time again. *Acad Med, 69*(3), 171.

Peterson, N. B., Friedman, R. H., Ash, A. S., Franco, S., and Carr, P. L. (2004). Faculty self-reported experience with racial and ethnic discrimination in academic medicine. *J Gen Intern Med, 19*(3), 259.

Pettigrew, T. (1975). *Racial Discrimination in the United States*. New York: Harper and Row.

Pettigrew, T. (1994). New Patterns of Prejudice: The Different Worlds of 1984 and 1964. In F. L. Pincus & H. J. Erlich (Eds.), *Race and Ethnic Conflict* (pp. 53). Boulder, CO: Westview.

Picca, L. H., and Feagin, J. R. (2007). *Two-Faced Racism: Whites in the Backstage and Frontstage*. New York: Routledge.

Pierce, J. L. (1995). *Gendertrials:Emotionallivesincontemporarylawfirms*. Berkeley: University of California Press.

Pololi, L., Cooper, L. A., and Carr, P. (2010). Race, disadvantage and faculty experiences in academic medicine. *J Gen Intern Med, 25*(12), 1363.

Portes, A. (1973). Modernity and Development: A Critique. *Studies in Comparative International Development, 8*, 247.

Portes, A. (1976). Determinants of the Brain Drain. *International Migration Review, 10*(4), 489.

Portes, A. (1996). *The New Second Generation*. New York: Russell Sage Foundation.

Portes, A. (1999). Conclusion: Towards a new world - the origins and effects of transnational activities. *Ethnic and Racial Studies, 22*(2).

Portes, A. (2009). Migration and development: reconciling opposite views. *Ethnic and Racial Studies 32*(1), 5.

Portes, A., Fernandez-Kelly, P., and Haller, W. (2005). Segmented assimilation on the ground: the new second generation in early adulthood. *Ethnic and Racial Studies, 28*(6).

Portes, A., and Ross, A. R. (1976). Modernization for emigration: the medical brain drain from Argentina. *Journal of Interamerican Studies and World Affairs, 13*, 395.

Portes, A., and Rumbaut, R. (2006). *Immigrant America: A Portrait* (3rd ed.). Berkeley: University of California Press.

Portes, A., and Rumbaut, R. n. (2001). *Legacies: The Story of the Immigrant Second Generation*. Berkeley, CA: University of California Press.

Portes, A., and Walton, J. (1981). *Labor, Class, and the International System*. New York: Academic Press.

Portes, A., and Zhou, M. (1993). The New Second Generation: Segmented Assimilation and Its Variants. *Annals of the American Academy of Political and Social Science, 530*, 74.

PRB. (2010). World Population Data Sheet. from Population Reference Bureau: http://www.prb.org/pdf09/09wpds_eng.pdf

Price, E. G., Gozu, A., Kern, D. E., Powe, N. R., Wand, G. S., Golden, S., et al. (2005). The role of cultural diversity climate in recruitment, promotion, and retention of faculty in academic medicine. *J Gen Intern Med, 20*(7), 565.

PricewaterhouseCoopers. (2007). Healthcare in India: Emerging market report 2007. from http://www.pwc.com

Purkayastha, B. (2005a). *Negotiating Ethnicity: Second-Generation South Asian Americans Traverse a Transnational World*. New Brunswick, NJ: Rutgers University Press.

Purkayastha, B. (2005b). Skilled Migration and Cumulative Disadvantage: The Case of Highly Qualified Asian Indian Immigrant Women in the US. *Geoforum, 36*.

Ramirez de Arellano, A. B. (2007). Patients without borders: the emergence of medical tourism. *Int J Health Serv, 37*(1), 193.

Ramsey, P. A. (1987). Young Children's Thinking about Ethnic Differences. *in Children's Ethnic Socialization: Pluralism and Development, edited by J. S. Phinney and M. J. Rotheram.Newbury Park,CA: Sage*.

Ramshaw, E. (2011, May 14). Cardiologists Accuse Hospital of Discrimination. *The Texas Tribune*.

Ranson, M. K., Sinha, T., Chatterjee, M., Acharya, A., Bhavsar, A., Morris, S. S., et al. (2006). Making health insurance work for the poor: Learning from the Self-Employed Women's Association's (SEWA) community-based health insurance scheme in India. *Social Science & Medicine, 62*, 707.

Rao, V., and Flores, G. (2007). Why Aren't There More African-American Physicians?A QualitativeStudyand ExploratoryInquiryofAfrican-American Students' Perspectives on Careers in Medicine. *JOURNAL OF THE NATIONAL MEDICAL ASSOCIATION*(9).

Raymer, S. (2004, 16 February). Indian Doctors Help Fill US Health Care Needs. *YaleGlobal*

Reichert, J. (1981). The migrant syndrome: seasonal US wage labor and rural development in central Mexico. *Human Organization, vol. 40*.

Report, C. (2007). *Foreign Medical Graduates: A Brief Overview of the J-1 Visa Waiver Programme*.

Richmond, C. (1993). Police come calling after British MDs act to expose racism in medicine. *Can Med Assoc J, 149*(1).

Ridgeway, C. L. (1982). Status in Groups: The Importance of Motivation. *American Sociological Review, 47*(1), 76.

Ridgeway, C. L., and Correll, S. J. (2004). Unpacking the Gender System: A Theoretical Perspective on Gender Beliefs and Social Relations. *Gender and Society, 18*(4), 510.

Roberts, B. (Ed.). (1993). *Socially Expected Durations And The Economic Adjustment Of Immigrants*.

Roberts, B., Frank, R., and Lozano-Asencio, E. (1999). Transnational Migrant Communities and Mexican Migration to the United States. *Ethnic and Racial Studies, 22*, 238.

Roberts, B. R., Frank, R., and Lozano-Ascencio, F. (1999). Transnational migrant communities and Mexican migration to the US. *Ethnic and Racial Studies, 22*(2).

Rojas, C., Samson, S. N., Ullilen, J. F., Amoateng-Adjepong, Y., and Manthous, C. A. (2011). Are international and American graduates equally ACGME competent? Results of a pilot study. *Conn Med, 75*(1), 31.

Rudman, L., and Kilianski, S. E. (2000). Implicit and explicit attitudes toward female authority. *Personality and Social Psychology Bulletin, 26*.

Rudman, L. A. (1998). Self-promotion as a risk factor for women: The costs and benefits of counter stereotypical impression management. *Journal of Personality and Social Psychology, 74*, 629.

Rudman, L. A., and Glick, P. (1999). Feminized management and backlash toward agentic women: The hidden cost to women of a kinder, gentler image of women managers. *Journal of Personality and Social Psychology 77*, 1004.

Rumbaut, R. G. (1994). The Crucible within: Ethnic Identity, Self-Esteem, and Segmented Assimilation among Children of Immigrants. *International Migration Review, 28*(4).

Sakamoto, A., and Kim, C. (2003). The Increasing Significance of Class, the Declining Significance of Race, and Wilson's Hypothesis. *Asian American Policy Review, 12*(19–42).

Santos, T. D. (1970). The Structure of Dependence. *American Economic Review, 60*, 231.

Saran, P. (1985). *The Asian Indian experience in the United States*. Cambridge, MA: Schenkman.

Sassen-Koob, S. (1988). *The Mobility of Labor and Capital: A Study in International Investment and Labor Flow*. New York: Cambridge University Press.

Saxenian, A. (1999). *Silicon Valley's New Immigrant Entrepreneurs*. San Francisco: Public Policy Institute of California.

Saxenian, A. (2002). *Local and Global Networks of Immigrant Professionals in Silicon Valley*. San Francisco: Public Policy Institute of California.

Saxenian, A. (2006). *The New Argonauts: Regional Advantage in a Global Economy*. Cambridge, MA: Harvard University Press.

Schiffman, M., and Frank, E. (1995). Harassment of women physicians. *J Am Med Womens Assoc, 50*(6), 207.

Schiller, N. G., Basch, L., and Blanc, C. S. (1995). From Immigrant to Transmigrant: Theorizing Transnational Migration. *Anthropological Quarterly, 68*(1), 48.

Schofield, J. W., and Francis, W. D. (1982). An Observational Study of Peer Interaction in Racially-Mixed 'Accelerated' Classrooms. *Journal of Educational Psychology, 74*, 722.

Sears, D. (1988). Symbolic Racism. In P. A. Katz & D. A. Taylor (Eds.), *Eliminating Racism: Profiles in Controversy*. New York: Plenum.

Segal, U. (1991). Cultural Variables in Asian Indian Families. *Families in Society, 72*(4), 233.

Sengupta, A., Shenoi, A., Sarojini, N. B., and Madhavi, Y. (2011). Human papillomavirus vaccine trials in India. *Lancet, 377*(9767), 719.

Sethi, R. C. (2003). Paula S. Rothenberg's edited 'Race, Class, and Gender in the United States: An Integrated Study' *Worth Publishers; Sixth Edition edition*

Shaffi, M., Ugargol, A., and Shah, A. (2007). Out-Migration of Health Care Workers and its Impact on Domestic Health Care in Kerala, India *IHEA 2007 6th World Congress: Explorations in Health Economics Paper*.

Shah, H. (1991). Communication and cross-cultural adaptation patterns among Asian Indians. *International Journal of Intercultural Relations, 15*, 311.

Sharon, B., Litt, J., and Wang, Y. (2004). Creating Status of Women Reports: Institutional Housekeeping as "Women's Work". *NWSA Journal, 16*(1), 194.

Sharpe, R. (2000, November 20). As leaders, women rule: New studies find that female managers outshine their male counterparts in almost every measure. *Business Week*.

Shervington, W. W. (2000). Top priority in the new millennium: ending 400 years of racism. *J Natl Med Assoc, 92*(1), 1.

Shetty, P. (2010). Medical tourism booms in India, but at what cost? *Lancet, 376*(9742), 671.

Shibutani, T., and Kwan, K. (1965). Ethnic Stratification. *New York:Macmillan*.

Shrier, D. K., Zucker, A. N., Mercurio, A. E., Landry, L. J., Rich, M., and Shrier, L. A. (2007). Generation to generation: discrimination and harassment

experiences of physician mothers and their physician daughters. *J Womens Health (Larchmt), 16*(6), 883.

Sinha, K., and Singh, M. K. (2008). India short of 6 lakh doctors *The Times of India*.

Sjoberg, G., Brymer, R., and Farris, B. (1966). Bureaucracy and the Lower Class. *Sociology and Social Research, 50*, 325.

Smith, R. (1995). *Racism in the Post-Civil Rights Era*. New York: State University of New York Press.

Smith, R. (Ed.). (1998). *Transnational localities: community, technology, and the politics of membership with the context of Mexican and US migration*.

Sohrabji, S. (2009). Neurosurgeon Awarded $1.6 Million in Gender Bias Suit.

Sood, M., and Chadda, R. K. (2008). Women physicians in India. *Natl Med J India, 21*(3), 154.

Spencer, M. B. (Ed.). (1987). *Black Children's Ethnic Identity Formation: Risk and Resilience of Caste like Minorities*. Newbury Park,CA: Sage.

Spivak, G. C. (1989). *Who claims alterity?* . Seattle: WA: Bay.

Stone, J. (1985). *Racial Conflict in Contemporary Society*. London: Fontana Press.

Stone, R. T., Purkayastha, B., and Berdahl, T. A. (2006). Beyond Asian American: Examining Conditions and Mechanisms of Earnings Inequality for Filipina and Asian Indian Women. *Sociological Perspectives, 49*(2).

Szymanski, A. (1981). The Political Economy of Racism. In S. G. McNall (Ed.), *Political Economy: A Critique of American Society* (pp. 321). Dallas, TX: Scott Foresman.

Szymanski, A. (1983). *Class Structure: A Critical Perspective*. New York: Praeger Publishers.

Takaki, R. (1987). *From Different Shores*. New York: Oxford University Press.

Takaki, R. (1989). *Strangers from a Different Shore*. New York: Penguin Books.

Tribune, T. (2008, July 7). Indian doctors complain of racism. *The Tribune*.

Tuan, M. (1998a). *Forever Foreigners or Honorary Whites? The Asian Ethnic Experience Today*. New Brunswick, NJ: Rutgers University Press.

Tuan, M. (1998b). *Forever Foreigners or Honorary Whites?: The Asian Ethnic Experience Today*. Piscataway, NJ: Rutgers University Press.

Tuan, M. (1999). Neither Real Americans nor Real Asians? Multigeneration Asian Ethnics Navigating the Terrain of Authenticity. *Qualitative Sociology, 22*(2).

Uba, L. (1994). *Asian Americans: Personality Patterns, Identity, and Mental Health*. New York: Guilford Press.

Unwin, L. (2001). Career progression and job satisfaction. *in N. Coker (ed.) Racism in Medicine, London: King's Fund*.

USNews. (2011). World's Best Universities: Computer Science. Retrieved April 25, 2012, from http://www.usnews.com/education/worlds-best-universities-rankings/best-universities-computer-science?page=2

Vertovec, S. (1999). Conceiving and researching transnationalism. *Ethnic and Racial Studies, 22*(2).

Vertovec, S. (2004). Migrant transnationalism and modes of transformation. *International Migration Review, 38*(3).

Wachter, R. M. (2006). International teleradiology. *N Engl J Med, 354*(7), 662.

Wadhwa, V. (2009). A Reverse Brain Drain. *Issues in Science and Technology, Spring 2009*, 45.

Warner, W., and Srole, L. (1945). *The Social System of American Ethnic Groups*. NewHaven: Yale Univ. Press.

Waters, M. (1990). *Ethnic options: Choosing identities in America*. Berkeley: University of California Press.

Waters, M. C., Tran, V. C., Kasinitz, P., and Mollenkopf, J. H. (2010). Segmented assimilation revisited: types of acculturation and socioeconomic mobility in young adulthood. *Ethnic and Racial Studies 33*(7).

Wei, W. (1993). *The Asian-American Movement*. Philadelphia: Temple University Press.

Weiss, M. (Ed.). (1973a). *Division and unity: Social process in a Chinese-American community*. Palo Alto: Science and Behavior Books.

Weiss, M. (Ed.). (1973b). *Division and unity: Social process in a Chinese-American community*: Palo Alto.

Wellman, D. (1977). *Portraits of White Racism*. Cambridge, England: Cambridge University Press.

West, C., and Zimmerman, D. H. (1987). Doing Gender. *Gender and Society, 1*(2), 125.

White, M. J., Fong, E., and Caic, Q. (2003). The segregation of Asian-origin groups in the United States and Canada. *Social Science Research, 32*, 148.

Williams, C. L. (1992). The Glass Escalator: Hidden Advantages for Men in the "Female" Professions. *Social Problems, 39*(3), 253.

Williams, C. L. (1995). Still a man's world. *Berkeley: University of California Press*.

Wong, B. (1977). Elites in Chinatown, New York City. *Urban Anthropology, 6*(1).

Woo, D. (2000). *Glass Ceilings and Asian Americans*. Walnut Creek: Altamira Press.

Wright, A. L., Schwindt, L. A., Bassford, T. L., Reyna, V. F., Shisslak, C. M., St Germain, P. A., et al. (2003). Gender differences in academic advancement: patterns, causes, and potential solutions in one US College of Medicine. *Acad Med, 78*(5), 500.

Wright, R. (1996). *The occupational masculinity of computing. In Masculinities in organizations*. CA: Thousand Oaks, Sage.

www.immigration.gov, h., from US Department of Justice, Immigration laws:

Xie, Y., and Goyette, K. A. (2004). *A Demographic Portrait of Asian Americans*. New York: Russell Sage.

Zhou, M. (1997). Segmented Assimilation: Issues, Controversies, and Recent Research on the New Second Generation. *International Migration Review, 31*(4), 825.

Zhou, M. (2004a). Are Asian Americans becoming white? *Context, 3*(1), 29.

Zhou, M. (Ed.). (2004b). *Assimilation in the Asian Way*. New York: Basic Books.

Zhou, M., and BankstonIII, C. L. (1998). *Growing Up American*. New York: Russell Sage Foundation.

Zhou, M., and Xiong, Y. S. (2005). The multifaceted American experiences of the children of Asian immigrants: Lessons for segmented assimilation. *Ethnic and Racial Studies, 28*(6), 1119

Zolberg, A. (1989). The next waves: immigration theory for a changing world. *Internacional Migration Review, 20*.

Zucca, G. J. (1979). *A Method of Assessment of Institutional Discrimination in the Navy* Patrick AFB, Fla: Defense Race Relat. Inst.