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Indian Immigrant Physicians in the US: A Gendered Transnational Perspective

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Indian Immigrant Physicians in the US: A Gendered Transnational Perspective

By

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I am especially grateful to the many international medical graduates around the country who took a break from their busy schedules to share their stories with me. I hope this study accurately presents and honors those stories, even those who are not included in the final study sample.

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Abstract

Background: The trend of physician out-migration from underdeveloped to wealthier nations—the so-called physician "brain drain"—has spurred widespread concern about the uneven global distribution of physicians, particularly in the world's neediest countries. Drawing heavily upon the sociological model of migration known as "push-pull theory," several survey studies have highlighted individual-level factors contributing to these migration flows, including the desire among doctors in developing countries for better pay scales and job security, better working conditions, more advanced hospital facilities, and a better quality of life for self and family.

Some migration researchers argue, however, that the push-pull theory is outdated or inadequate to explain the dynamic social forces at work among contemporary highly skilled migrants. Transnational theories of migration emphasize the sustained linkages between migrants and their communities, which influence the ways in which migrants interact with the home country from abroad. Simultaneously, gender and other broad social and cultural forces are becoming increasingly important in the sociologic understanding of international migration.

Aims: India is a country with particularly high rates of physician emigration, largely to the United States. This study aims to add depth and nuance to the current understanding of Indian physician migration, with an attention to transnational and gendered forces.

Methods: Fifteen qualitative interviews were conducted over a period of six months with Indian physicians who have already settled in the US. Using a broad interview

guide, the interviews traced participants' migration trajectories and examined the social forces and processes that enabled and constrained these trajectories. Interviews were coded and analyzed using a thematic narrative method.

Summary of Findings: Six out of eight male participants described a "linear" trajectory, in which their primary aim in migrating to the US was to obtain a position in a medical residency program. In contrast, five out of seven female participants described a "triangular" trajectory, in which migration and a US medical residency were influenced and/or enabled by marriage to a US-based Indian spouse. In this and other important ways, gender emerged as an influential force shaping Indian physicians' migration trajectories. In addition, transnational communities appear to shape participants' ideas about and interest in migrating to the US, as when Indian medical graduates hear about friends' and classmates' immigration experiences. For women in particular, transnational communities may influence migration opportunities by creating a marriage market that spans the global Indian diaspora.

Based on these findings, this study argues that while "push" and "pull" factors undoubtedly influence Indian doctors' migration decisions, these factors do not exist in a vacuum. Medical migration is further influenced, enabled, and constrained by larger social forces, including transnational communities, family expectations (particularly the marriage priority), and the rapid pace of social and economic change in the country.

Background and Significance

1. Introduction

The trend of physician out-migration from underdeveloped to wealthier nations—the so-called physician "brain drain"—has spurred widespread concern about the uneven global distribution of physicians, particularly in the world's neediest countries (AMA 2010; Kaushik 2008; Mullan 2005). Drawing heavily upon the sociological model of migration known as "push-pull theory," several survey studies have asked doctors from developing countries to name or rank their reasons for emigrating in order to elucidate on an individual level the forces that contribute to the "flight" of these physicians (Syed 2008; Akl 2007; Chacko 2007; Hagopian 2005). These studies have highlighted issues such as the desire for better pay scales and job security, better working conditions, more advanced hospital facilities, better quality of life for self and family, as well as a "culture" of migration in countries and medical schools with particularly high rates of physician emigration, among other reasons (Akl 2007; Astor 2005; Hagopian et al. 2005).

Some migration researchers argue, however, that the push-pull theory is outdated or inadequate to explain the dynamic social forces at work among contemporary highly skilled migrants. The emergence of transnational networks, transformations in social life and family structure, shifts in government policies, and the rapid economic growth of certain developing countries have all been shown to impact migrant mobility and decision-making (Harvey 2009, Nowak 2009, Rao 2008, Levitt & Jaworsky 2007, Vervotec 2002). Furthermore, the increasing proportion of female migrants (sometimes called the "feminization" of international migration) has prompted a call for attention to the interconnections between gender, migration, and transnational movement

(Dumont 2007, Levitt & Jaworsky 2007, Purkayastha 2005, Pessar and Mahler 2003, Hondagneu-Sotelo 1999, Pessar 1999).

Immigrant physicians, particularly those from the highest physician-exporting countries of South Asia, constitute a skilled immigrant group of strategic importance to both domestic and global public health workforces. Every year, India contributes more doctors to the United States than does any other foreign country, and Indian-educated doctors constitute five percent of the US physician workforce (Mullan 2005). At the same time, it is feared that outmigration of Indian physicians is a detriment to that country's already over-burdened healthcare system (Kaushik 2008; Cooper 2005; Mullan 2005).

In light of the domestic and global importance of this issue, the present study seeks to add depth and meaning to the current understanding of Indian physician migration. It does this by abandoning a purely individual-level analysis and viewing medical migration instead as a social process: a series of decisions, reflections, and next steps, all of which are significantly influenced by social forces beyond the individual—including family, community, and national-level forces. It does this by asking Indian physicians who have already settled in the US to reflect on their trajectories and to explore the social forces and processes that enabled and constrained their migration. With a sample evenly divided between male and female migrants, the study pays particular attention to the role of gender in shaping the migratory and professional trajectories of Indian IMGs.

The relevant background presented below includes an introduction to public health, family and social structure, and education (specifically medical education) in India, which establishes the context for the present study. This is followed by an outline of the process by which an

international medical graduate (IMG) may obtain a medical residency in the United States and an explanation of the important role of IMGs in the US medical system. Finally, a review of the literature on skilled migration and the physician "brain drain" summarizes what is known and highlights some important gaps in that knowledge, which the present study aims to fill.

2. The Context of the Research

2.1 India: A country of rapid and transformational change

In the past quarter century, India's rapid economic growth and high visibility in the global high-tech and telecommunications industries have contributed to its image as an emerging powerhouse on the world economic stage. Consistent democratic rule—including vibrant and competitive opposition parties and regular free elections— has contributed to India's visibility and facilitated increased economic and political partnership with the US and other western democracies.

Although it is still considered a developing economy, India's consistently high economic growth (achieving rates of 8 – 9% over the past several years) makes it a promising place for its enormous population under the age of 25 (Bajaj 2010). Metropolitan technological hotspots such as Bangalore and Hyderabad, India's twin "Silicon Valleys," consistently attract global attention for their role in the information technology (IT) sector, telecommunications, biotechnology

research industries, and medical institutions. Throughout India's urban centers, the medical private sector is a promising field for economic and technological expansion. Likewise, industries such as medical tourism offer increasingly lucrative practice opportunities for India's best doctors to work with ever advancing technologies and an international population.

India's rapid pace of growth and change has been shown to be a factor affecting young Indian professionals' decisions about whether to work and settle abroad, as they consider not only prospects for personal and professional advancement, but also opportunities to "make a difference" in the development of their home country (Chacko 2007).

Unfortunately, India's phenomenal growth and its wealth of human resources are countered by the realities of extreme poverty in which the vast majority of the population lives. India remains the country with the world's highest number of persons living in extreme poverty. While recent generations of the upper-middle classes have enjoyed rapid advances in wealth and standards of living, the ranks of the rural and urban poor bear the brunt of India's weak infrastructure, including a terribly underfunded public health sector.

2.2 Public Health in India

India's burden of disease—especially from communicable diseases such as HIV/AIDS, leprosy, and tuberculosis—is enormous. Malnutrition and lack of clean drinking water are rampant problems: 23 percent of children are born at low birth weight, and acute diarrhea accounts for 12 percent of deaths due to communicable diseases (Abassi 1999). Public health indicators are grim: A life expectancy of sixty-five years, infant mortality rate of nearly sixty per 1,000 births (down from eighty in 1990), and maternal mortality ratio (MMR) of 300 per 100,000 live births, all

place India far down on the list of developing countries according to public health measures (SEARO 2009).

The World Bank has criticized India for making inadequate efforts to address its public health problems (Abassi 1999). Expenditures on health amount to just under five percent of India's gross domestic product (WHO SEARO 2009). At least 75 percent of these funds come from the largely unregulated private sector, which offers "some of the best and the worst care seen anywhere" (Abassi 1999). India's high rate of physician emigration, some argue, is another factor impacting the country's overall health.

2.3 Medicine in India

In 2006, a paper by Fitzhugh Mullan in the journal *Health Affairs* presented an "exposé" of India's medical education system and the driving forces behind its high rate of physician emigration. Based on interviews with medical education leaders, health policy makers, and public health officials, Mullan concluded that policies to discourage and curtail physician emigration are necessary "to better the health of all of India's people." While his recommendations are clear, the picture he paints of India's healthcare system and its healthcare workforce are complex and nuanced.

About 600,000 physicians are currently registered by the government of India (although Mullan points out that the number actually practicing is lower, due to emigration and retirement). This places India's mean physician-to-population ratio at approximately 60 per 100,000—about half the world average—but the distribution is heavily skewed toward urban areas. Although the World Health Organization (WHO) has identified India as a country with a "critical shortage" of

health service providers (WHO 2006), these shortages are not obvious among the urban middle class, where the physician-to-population ratio comes close to 200 per 100,000 (comparable to the ratio in the United Kingdom). The uneven distribution of physicians between the middle class and the rural poor explains some of the debate within India as to whether a physician shortage exists at all (Mullan 2006).

2.4 Social and family structure in India

Any study of India or Indians must take into account the country's enormous geographic, ethnic, socioeconomic, and cultural diversity. Volumes have been written on the topic, which only scratch the surface of the nuances and diversity of Indian society.

Nevertheless, certain cross-cutting themes can be observed throughout the country with some consistency, including traditional gender norms, a patriarchal joint family structure, and the high ritualistic and institutional value of marriage, which functionally joins not just two individuals but two families (Mullatti 1995; Mehta 1970).

Traditional Indian gender norms give women primary responsibility for the domestic sphere, including child-rearing and home-making, while male gender norms emphasize the husband's responsibility for paid work outside of the home. In reality, across socioeconomic class and education status, both men and women often work outside the home and contribute to family income (Mullatti 1995.) In the patriarchal family structure, males in the family are generally responsible for decision-making for the rest of the family, as well as for the "physical and moral protection" of family members (Mullatti 1995; p.16).

Ninety-five percent of marriages in India, including those among the middle-class, are arranged marriages, by which partner selection is facilitated largely or solely by parents and other family elders. Although inter-religion and inter-caste marriages are legal and do occur, generally religious and caste endogamy are preferred by families, along with educational and occupational compatibility between the man and woman (Mullatti 1995). Often considered a highly traditional South Asian tradition, variations on the arranged marriage custom in fact persist to a large degree among the urban, educated middle-class (Chawla 2007; Mullatti 1995): Generally, parents select prospective mates from a suitable pool (which may be extremely limited or quite broad); the man and woman are then introduced and may have significant input (or even the final say) in the selection process. (Sharangpani 2010).

In the traditional joint family, the bride joins her husband's family following marriage, and multiple generations live together in the same family home. As westernization and international mobility increasingly separate joint families into nuclear units, this tradition persists in the expectation that the newly married woman will join her husband in his place of work (Sharangpani 2010, Mullatti 1995); for example, an Indian woman who marries an Indian man living and working in the US would be expected to leave her family to join him there.

As Sharangpani notes in her ethnographic study of modern matchmaking in India, "arranged marriages provide a particularly useful arena within which to observe the tension between traditional notions of family-making and modern desires of individual growth." Her study suggests that modern middle-class Indian women who enter into arranged marriages may "recognize and seize personal opportunities made possible by such alliances and in so doing, reconcile the notions of 'personal' and 'social' choice'" (Sharangpani 2010; 254). Thus a gendered approach to understanding medical migration (such as that of the present study) must

be attuned to the tensions and reconciliations that emerge from individual, familial, and societal motivations around personal and professional decision-making, particularly for young women entering the demanding and technologically "modern" field of medicine.

Finally, traditional Indian family values heavily emphasize education, with the understanding that "the success of the children ensures the success of the family" (Sharangpani 2010). Thus schooling and testing can be quite rigorous for Indian children, as test scores ultimately determine eligibility for higher education and professional training spots in the public education system.

2.5 Medical training in India

Medicine, along with engineering, is one of the most respected and popular professions in India (Mullan 2006). Each year more than 100,000 students take medical school entrance examinations upon secondary school graduation, competing for tuition-free seats in government medical colleges.

Graduates of Indian medical school exit with a Bachelor of Medicine and Bachelor of Surgery degree (MBBS), and they require no further training to practice medicine in India. Postgraduate training for specialization is available, but postgraduate training spots within India are extremely competitive. Immigration abroad—where medical residencies and fellowships offer opportunities for specialization as well as a mark of prestige—is an attractive alternative for many.

Indian author Saranaya Nandakumar summarizes in the popular literature some of the main reasons for Indian doctors to seek training overseas: In addition to the lure of specialized training and the lack of postgraduate opportunities in India, many young doctors and their families view foreign medical training as superior to that offered in India, and/or as a mark of prestige and achievement. Expectations of greater income, better working hours, and improved lifestyle overseas are coupled with the desire to escape poor working conditions and bureaucratic challenges of medical practice in India (Nandakumar 2004).

2.6 Indian physicians in the US

For Indian immigrant doctors who seek further training and specialization abroad, English-speaking countries are particularly attractive: Nearly 60,000 of them (or roughly 10% of licensed Indian physicians) currently practice in the United Kingdom, Canada, Australia, or the United States. Immigration policies in these countries are relatively favorable for skilled workers, particularly where shortages of domestic doctors create a high demand for IMGs.

In 1965, the United States Immigration and Naturalization Act dramatically changed immigration laws and trends in the US. The Act abolished a longstanding national-origin quota system and increased family reunification visas and visas for highly trained migrants entering strategically desirable occupations (largely in the sciences). While the expectations and intentions of the US Congress in passing the Act were a matter of controversy, the resulting immigration shift was dramatic: Among other important demographic changes, the number of immigrants from developing Asian countries soared. The 1970 census recorded a mere 51,000 Indian-born migrants in the US. By 2006, the number had grown nearly 30-fold to 1.5 million,

making Indians the fourth largest immigrant group in the United States[1]. In 2006, the American Community Survey reported that among Indian-born adults in the US, 4.8 percent of men and 5.8 percent of women were practicing physicians (Terrazas 2008).

The growing contribution of Indian physicians and other IMGs to the US physician workforce can be explained almost entirely by growing demand. As the number of first-year medical residency positions in the US expands each year, the number of US medical graduates (USMGs) has not kept up. In 2007, the Association of American Medical Colleges reported that only 15,206 USMGs applied for the 21,845 available first-year residency slots—less than 70% of the total positions. The remaining 30 percent were filled mostly by IMGs (AAMC 2007).

The application process for IMGs, coordinated by the Educational Commission for Foreign Medical Graduates (ECFMG), is lengthy and complicated—an entire academic paper is necessary to explain it in full (see Leon 2006). The three major steps are 1) receipt of ECFMG certification, 2) obtaining a visa, and 3) being accepted into a US residency program. Each of these is "an uphill battle, expensive, and time-consuming" (Leon 2007). A summary of the process is provided in *Figure 1* (Leon 2007:490).

The growing discrepancy each year between the number of US residency slots (supported by Medicare funds) and the number of USMGs reflects a "critical need for IMGs' services…, especially in marginal, health professional shortage areas" (Leon 2007). IMGs generally compete for the spots left un-filled by USMGs, either on national Residency Match day or in the post-Match "scramble." Those spots may be considered less desirable by domestic applicants, often because of "unwanted geographic location," "poor training, and other negative qualities" (Leon

[1] The top three immigrant groups at that time were Mexican, Filipino, and Chinese.

2007). These are often primary care and family residency positions, located in remote areas or in badly understaffed urban county hospitals.

In addition to the application process, IMGs face the challenge of securing a visa to live and work in the United States. Those not eligible for dependant status or family sponsorship must apply for temporary visas—for the most part J-1 education and training visas and H1-B temporary worker visas—through the ECFMG or directly through their residency program.

Despite the rigorous and expensive application process for spots in relatively "undesirable" programs, IMGs—Indians in the highest numbers—continue to compete for US residency positions every year. While the individual motivations for physician migration have been detailed by the health policy literature, the attendant social forces—including gender—that shape these motivations and enable or impel migration have been left relatively unexplored.

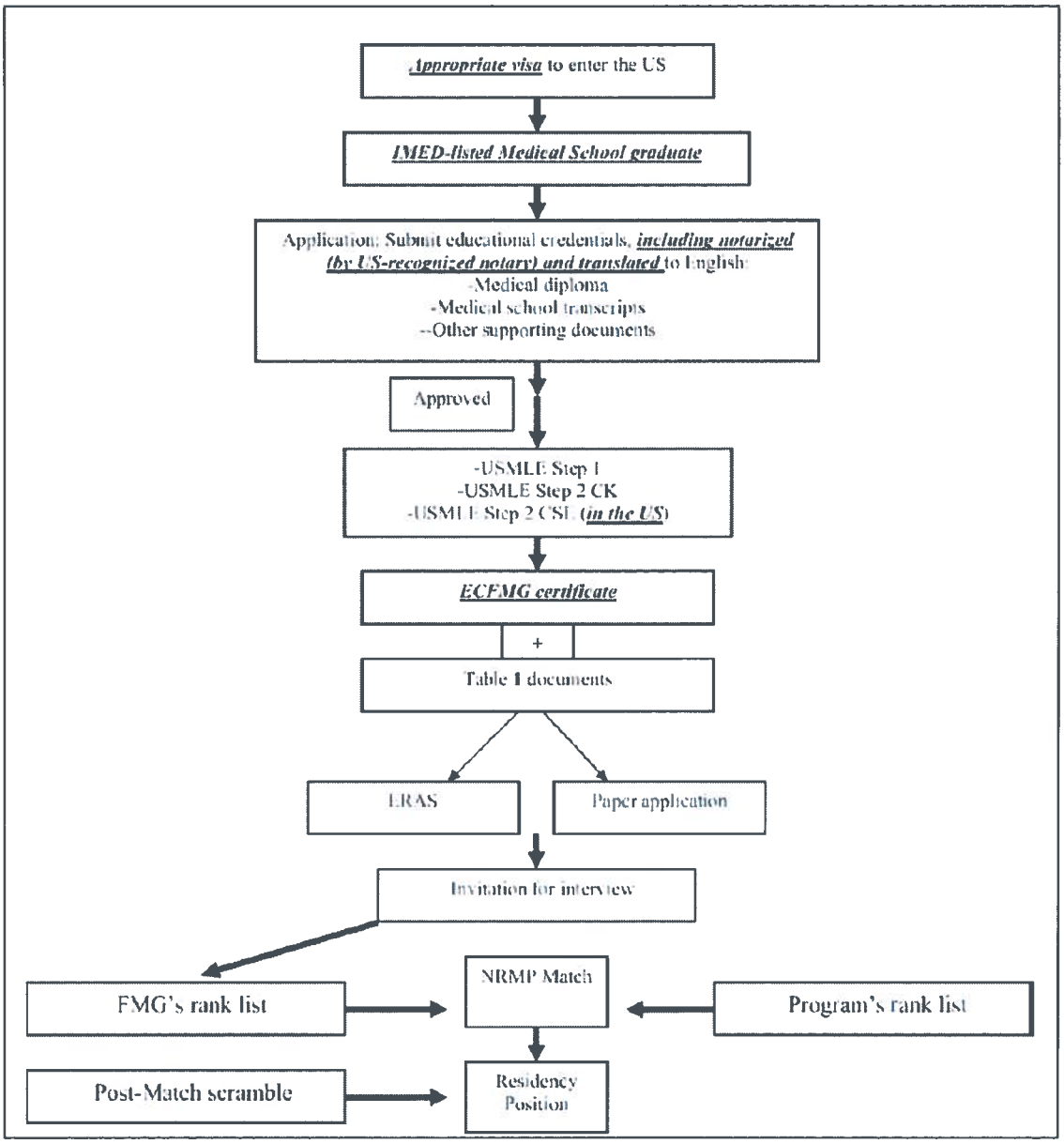

Figure 1. Typical road for an international medical graduate to obtain graduate medical education in the US. FMG, Foreign Medical Graduate (equivalent to International Medical Graduate, as used in this paper); *ECFMG, Educational Commission for Foreign Medical Graduates; ERAS, Electronic Residency Application Service; IMED, International Medical Education Directory; NRMP, National Residency Matching Program; USMLE, US Medical Licensure Examinations. Table 1 documents refers to the paper from which this figure is adapted: Leon 2007.*

3. THE STATE OF THE LITERATURE

3.1 Sociology of migration: Traditional approaches

The global health literature has drawn upon longstanding sociological theories of migration to explain and propose solutions to the physician outmigration from developing countries. For the most part, these are based on individuals' motivations for migrating, or on structural factors, or both (Ravenstein 1889; Lee 1966; Portes and Walton 1981).

On a "micro" level of analysis, individual migrants' decisions are often modeled by push-pull theory. First proposed by Ravenstein (1889) and formalized by Lee (1966), push-pull theory outlines the manner in which unfavorable circumstances "push" individuals out of their home region, and real or perceived favorable circumstances in another location "pull" them toward resettlement. Studies applying push-pull theory to physician migration cite common push factors in (usually underdeveloped) home countries, including low pay and poor working conditions. In addition to the higher salaries and better working conditions, pull factors associated with training and practicing medicine in wealthier "recipient" countries include job security and perceived prestige (Hagopian 2005; Dodani & LaPorte 2005).

Despite its usefulness for understanding migration at the level of the individual, push-pull theory has been widely criticized by migration "structuralists" for decontextualizing individual decisions and ignoring the systemic factors that influence large-scale migratory patterns, such as the role of governments and multi-national corporations in shaping markets and controlling global mobility (Portes and Walton 1981). Structuralist approaches emphasize the importance of state migration policies, government and private recruitment efforts, and global trade laws and patterns that in turn shape migration flows.

Until recently, the dominant view of migration—including that of highly-skilled professionals—has been as a static and one-way process. Traditional migration research focused on either the forces that initiate and sustain migratory flows (like the two models described above), or on the adaptation and assimilation of migrants who have already settled in a new country (Vertovec 2009). These approaches, by focusing on specific moments either before or after migration, neglect to consider the temporality and directionality of migration flows. The health policy literature, in its reliance on these approaches, largely reflects this out-dated approach to understanding the movement of individuals around the globe.

3.2 Transnationalism and the potential for "brain exchange"

Several scholars now suggest that migration is better understood as a flexible and dynamic process, in which migrants maintain active ties to their home countries, influencing and being influenced by communities there and by communities in the destination country. The concept of *transnationalism* is widely used to describe this phenomenon.

Applied across a range of social and political disciplines, transnationalism can be defined as "sustained cross-border relationships, patterns of exchange, affiliations and social formations spanning nation-states" (Vertovec 2009). More specifically, transnational migration refers to the "processes by which immigrants forge and sustain multi-stranded social relations that link together their societies of origin and settlement" (Basch, Glick Schiller, and Szanton Blanc 1994).

Alongside and in communication with transnationalism, the topic of skilled migration has since the 1990s attracted increasing research attention. Transnational skilled migrants have been of

particular interest as their movements back-and-forth across and around the globe gain significance for flows of business and capital (Vervotec 2002). Yet only a handful of qualitative studies have addressed the experiences and decisions of skilled migrants *over time*—exploring not only how migrants came to leave home initially, but how they further shape (or are shaped by) their professional and migratory trajectories, and why they do or do not consider returning home later in life (Harvey 2009; Chacko 2007; Saxenian 2006).

Skilled immigrants from India are in many ways prototypical transnationals. Their extensive social networks, often spanning multiple continents, exemplify modes of transnational movement and communication (Radhakrishnan 2008; Chacko 2007; Saxenian 2006). In her study of Indian IT professionals who return from the US to Bangalore and Hyderabad, Chacko (2007) shows evidence of a "reverse brain-drain" and investigates the reasons for her subjects' return. Her participants cite the appealing "dynamism" of globalizing cities in India, a desire to reconnect with their heritage, and an awareness of growing job prospects as reasons to return. She concludes that this "transnationally active labor force" is not only helping to thrust the Indian IT sector forward, they are also impacting "physical and social infrastructure" through their capital and social investments (Chacko 2007, 128).

This concept of "reverse brain drain," "brain circulation," or "brain exchange" is gaining traction in the skilled migration literature. Several authors, most notably AnnaLee Saxenian (2006), now argue that brain circulation among skilled migrants from developing countries has changed the face of the "brain drain." Saxenian argues that by investing in and/or returning home, highly skilled migrants from India, China, and Taiwan are contributing to the economic development of their home countries, even after having migrated temporarily or permanently to California's Silicon Valley. Hoping to encourage and benefit from these trends, countries such as India and

Taiwan are increasingly implementing policies to incentivize return among highly skilled migrants abroad. The Indian government, for example, has attempted to promote brain circulation by allowing dual citizenship for non-resident Indians (NRIs) and establishing a dedicated ministry for the purpose of serving the needs and eliciting the support of NRIs (Patterson 2006, p. 1900, cited in Harvey 2008). (Once called the Ministry of NRI Affairs, the ministry was renamed in 2004 to the Ministry of Overseas Indian Affairs.)

Following Saxenian's work, Harvey (2008; 2009) specifically addresses whether and why skilled Indian immigrants might invest in or consider permanently returning to India. (Return migration among highly skilled Indian migrants is a topic that has also received some attention in the popular media [Knox 2007]). Based on interviews with Indian and British scientists living in Boston, he concludes that while more of the Indian scientists had considered making future investments in the Indian economy, few had actually done so (Harvey 2008). Likewise, few Indian scientists plan to return permanently to India. Of the Indian scientists who do consider returning, professional opportunities in India are seen as an important factor influencing this decision—more so than for British scientists living in Boston, who express significantly less optimism about the possibility of returning home. His findings suggest that skilled migrants from developing countries hold a greater desire to return home than their counterparts from developed countries, perhaps especially when rapid economic growth in one's home country is seen as a harbinger of potential opportunity (Harvey 2009).

3.3 Gender and transnationalism

Several authors have recently highlighted the importance of gender in the context of skilled migration and transnational labor markets, as gender gains increasing recognition for its influence in all social processes, and as women make up an increasing percentage of international skilled migrants.

Pessar emphasizes the role of gender "as a central organizing principle in migration," one which creates different migration experiences for men and women and impacts "settlement, return, and transmigration" (Pessar 1999). She notes that "researchers have only recently begun to explore how changing politico-economic conditions in labor-exporting and labor-importing societies differently affect men and women and how this, in turn, may provide them with contrasting incentives and constraints on movement and foreign settlements" (Pessar 1999; 580). This is precisely the work of the present study, which focuses on the social forces impacting Indian men and women in the medical profession, who fill a unique role in the health and development of their own country as well as the global health workforce.

One recent study taking a similar conceptual and methodological approach is Nowak's interview-based analysis of gendered perceptions of international migration among Ghanaian nurses (2009). Noting the recent shift from male-dominated to increasingly "feminized" flows of migration, Nowak's study raises the question of why skilled women migrate, with a particular focus on changing attitudes toward the migration of skilled women in the nursing profession. She points to the flexibility of gender norms and the ways in which women strategize to "adapt gendered responsibilities to their migration activity" (Nowak 2009; 274), a phenomenon that is presumably of relevance in other labor-exporting countries—such as India—in which women's

roles traditionally have been inconsistent with independent international migration. Similar findings are suggested in Sharangpani's study of arranged marriages in Mumbai (formerly Bombay), in which she describes that where the pressure to marry is "too strong to resist," migration through marriage may be a solution that holds some personal and professional incentives for the bride (Sharangpani 2010, 267).

Purkayastha's study of highly skilled Asian Indian immigrant women in the United States focuses on the post-migration challenges of non-white married women in the American workforce, who must simultaneously adjust to living in a new country while balancing career ambitions with marital and domestic responsibilities—what she calls "balancing work and care-work" (Purkayastha 2005, 191). Her study emphasizes that even highly skilled women often migrate officially "as wives"— creating a false distinction which obscures women's unique experiences and undermines a complete and gendered understanding of migration's true meaning in these women's lives. The author calls for greater attention to be paid to "what migrating as wives means for women, especially for women with high human capital" (Purkayastha 2005, 181). While the present study examines the social forces that impact the migration and professional trajectories of both men and women, the dual role of women as family members (both as wives and daughters) *and* as physicians emerges as an important and unique component of women's roles in transnational communities and migrant flows.

3.4 Rationale for the present research

Taking into account the transnational nature of Indian middle class communities, India's dynamic economic growth, and the emerging recognition of the importance of gender in

migration studies, this study explores the ways in which these and other social forces shape Indian medical graduates' migration trajectories—from the initial decision to leave India, to the experience of migration, to later decisions about where to live and practice medicine.

While the push-pull theory has been widely applied to an understanding of medical migration in countries such as India, it is hypothesized that this model offers only a superficial view of the decision to migrate. The in-depth, narrative interview approach of the present study aims to explore the various social forces that constrain, encourage, or enable such decisions. Specifically, the study asks how gender impacts migrants' opportunities and/or decisions to migrate, whether Indian physicians have the potential to engage in "brain exchange," and how Indian physicians think about the global distribution of healthcare workers and their place in the global health workforce.

4. STUDY QUESTIONS

The project asks three key questions:

1) How do Indian international medical graduates (IMGs) think about and describe their migration trajectories?

2) What does transnationalism look like among Indian IMGs, and how does it shape their migratory trajectories?

3) How does gender influence the migratory and professional trajectories of Indian IMGs, and how does gender as a social force intersect and interact with transnationalism?

5. METHODS

5.1 Confidentiality and protection of human subjects

This research study was approved by the University of California, Berkeley's Committee for Protection of Human Subjects (CPHS), the University's Institutional Review Board. Consent was obtained from all subjects (see Appendix: Informed Consent), according to CPHS regulations. All names and identifying information have been changed in order to protect participant confidentiality.

5.2 Sampling and recruitment

Eligibility criteria—as outlined in a recruitment email—included residents and physicians who:

1) were born and raised primarily in India;
2) completed undergraduate medical training in India;
3) immigrated to the US in the past 10 years.

The 10-year time limit was included in order to limit the sample to those doctors who immigrated after the popularization of the internet, email, and cheap international telephone fees, as these developments have been shown to be important factors in facilitating global linkages within diasporic communities over the past decade (Vertovec 2009).

Recruitment began with a convenience sample of Indian IMG residents and physicians in northern and central California. Through two key informants on the house staff of a large Bay Area county hospital (a hospital known for its relatively high proportion of IMGs), permission was obtained for recruitment and interviewing of eligible physicians. A subsequent round of

recruitment was conducted in a similar manner at another large teaching hospital in California. A compensation of fifty dollars was offered in this round, in order to improve response rates. (See Appendix: Recruitment Email.)

From these initial contacts, recruitment proceeded in a "snowball" fashion, as each participant was asked to provide contact information or to pass along recruitment materials to his or her eligible contacts.

Ultimately, fifteen participants were included in the study: eight men and seven women. Most participants had grown up and/or attended medical school in urban and semi-urban areas in northern and central India; three were from southern India. One participant attended high school in Kuwait, returning to India for medical school; another participant attended medical school in Eastern Europe, returning to India to practice medicine briefly before moving to the US to pursue a medical residency. Although this participant did not strictly fit the inclusion criteria, he was included in the sample because he intended to and did for some time practice medicine in India, and his remarks in the interview were found to be consistent on many levels with other participants' perspectives. Participants' ages ranged from 24 – 34 years old. Most participants were residents in internal medicine or family medicine at the time of the interview; only one participant had completed his residency.

More demographic details of the participant sample can be found in the "Narrative Summaries" at the end of this section.

5.3 Narrative inquiry and thematic analysis

The methods of this study are directly linked to its substantive aims. The questions of why and how Indian physicians come to migrate to the US are largely questions about process and change. As described by Weiss (1994), qualitative interviews are ideally suited for eliciting the processes behind observed events or phenomena, because the interview participants are able to describe sequences of events and the ways in which various processes and factors combined into an ultimate course of action. Given the bureaucratic, logistical, and emotional complexities that accompany immigration to the US, this level of detail is imperative to paint a complete, nuanced picture of Indian physician migration.

As Frankel and Devers argue in their guide to qualitative study design in health and education, "Qualitative methods are needed when the questions that are being asked pose puzzles that are difficult, if not impossible, to address using conventional research approaches" (Frankel & Devers 2000). The "puzzle" of this study is to understand the ways in which IMGs *interpret and frame* their personal and professional identities and their life trajectories. That is, how do these individuals see themselves? What are their values, attitudes, and self-constructed identities in relation to both the US and India? The data needed to describe IMGs' migration processes and their interpretations of these processes could not come from a standardized questionnaire—they required the telling of a unique, self-constructed story by each participant. For this reason, interviews were conducted using a "narrative inquiry" approach, in which the participant is encouraged to tell his or her own account of an experience as it unfolds most naturally, prioritizing and organizing topics according to what he or she feels is most important or relevant. This approach allows the researcher to continue to learn from participants about their conditions

and experiences, while simultaneously observing patterns and developing themes for further inquiry and analysis.

Fifteen interviews were conducted over a period of six months. Interviews were conducted mainly in hospital conference rooms, homes, and coffee shops—wherever and whenever doctors could carve out an hour from their work and family commitments. A broad interview guide served as a checklist for important topics, rather than a manual as to the scope or sequence of questions (see Appendix: Interview Guide). As much as possible, participants were encouraged to direct the pace and order of the interview, telling their stories as they chose. Participants were asked to talk about "whatever you think is most important;" and every interview concluded with the question, "Is there anything else you want to talk about?" For the most part, participants related vivid narratives, making sense and meaning of events in a logical, though not necessarily chronological order.

As an interviewer, I found that by giving interviewees a good deal of control in the process, I allowed myself to be gradually pried away from my own priorities and assumptions as to what we would talk about. Instead, the process naturally highlighted what participants thought was most important, which ultimately led to some of the study's most interesting findings.

As with all qualitative research, the study design remained—by necessity—emergent and flexible. Informed by early findings, subsequent data collection and analysis procedures were modified in order to gather more specific information, or explore new and unanticipated areas of interest to the research questions.

Consistent with the goals and methods of data collection, analysis was performed according to a holistic coding method known as narrative thematic analysis, in which broad narrative arcs are

analyzed for themes that recur in meaningful patterns across multiple interviews (Riessman 2008). In contrast to grounded theory, in which coding is often based on smaller chunks of text, phrases, or individual words, narrative thematic analysis preserves the narrative scope and trajectory (or multiple trajectories) of each interview. After a preliminary analysis had been drafted, it was submitted to participants to solicit feedback, concerns, and suggestions.

Although time limitations precluded longitudinal data collection, retrospective and prospective narrative arcs were captured to some degree in questions regarding participants' past experiences and future plans, allowing for an understanding of how these experiences and plans had evolved—and continued to evolve—*over time.*

5.4 Narrative summaries

The following list includes each participant's gender and a brief narrative summary of his/her path to a US residency. This is intended as a reference to help the reader keep track of "who's who" while reading the analysis. Names and identifying information have been changed.

Aditi *(f) is a 3rd year pediatrics resident at a large California hospital. She is married to a software engineer based in California's Silicon Valley. Their marriage was arranged by their families, with help from the Indian match-making website Shaadi.com. Having already completed two years of pediatrics residency in India, Aditi moved to the US after her marriage and prepared to apply for US pediatrics residencies.*

Ahmad *(m) is a 1st year resident at a large university-affiliated hospital in central California. His primary motivation for pursuing a US residency after medical school was to get a "big University name" on his resume. He is currently single. Although his parents are eager for him to get married soon, for the time being they are "fine with whatever I do."*

Deepthi *(f) is a 1st year pediatrics resident at a large University-based hospital in the Midwest. After graduation from medical school, she decided to pursue postgraduate training overseas in order to have a better chance at a residency in pediatrics, and to gain experience practicing medicine in a different country, which she could take back with her to India. She is currently single and feels no pressure from her family to get married.*

Dev *(m) is a 3rd year family medicine resident at a large university-affiliated hospital in central California. After graduating from medical school he immediately took his US licensing exams*

and secured a residency and an H1-B visa at a hospital in Arkansas. Following his first year of residency, he married a first-generation US citizen from India whom he met on Shaadi.com. He managed to transfer to a different residency program in California, where he and his wife now live with their one-year-old son.

***Kunjal** (f) is a 1st year internal medicine resident in a community hospital in New York City. She graduated from medical school in 1992, completed a residency in Obstetrics-Gynecology in India, and practiced there for a few years before getting married to her husband, a Silicon Valley-based software engineer from India. She accepted a pre-match position in her current program and hopes to transfer to a California hospital next year, to be closer to her husband.*

***Maya** (f) is a 1st year internal medicine resident at an urban county hospital in California. She applied to US residencies despite much resistance from her parents, who are concerned about the fact that she is unmarried. She plans to pursue a rheumatology fellowship after her residency, and she is eager to use her training improve diagnosis and treatment of rheumatologic diseases in India.*

***Niel** (m) is a 1st year internal medicine resident at a university hospital in southern California. He has been planning on pursuing a US residency since medical school, with much support from his parents, who are both doctors. He plans to pursue a fellowship in interventional cardiology and then to return to India and join his parents' practice. He is unmarried.*

***Pradeep** (m) is a 1st year internal medicine resident a large university-affiliated hospital in central California. As a medical student, after witnessing the many barriers to providing quality care in India, he decided to pursue a US residency. He was unsuccessful in his first match*

process. After working at a prestigious pathology lab for one year, he was offered a pre-match at his first choice program. He is unmarried.

Priya *(f) is a 3rd year family medicine resident at a large university-affiliated hospital in central California. She and her husband were married in India, and moved to the US together after he was offered a lucrative job opportunity. At that time, she was part-way through an internal medicine resident in India, and she was not thrilled about giving up that position to move to the US. Her husband now lives and works about five hours away by car, commuting on the weekends. They have one baby, and their parents visit from India for months at a time to help with childcare.*

Rohit *(m) is a 1st year internal medicine resident at a community hospital in New York City. His father, also a physician, trained at Harvard. He has always encouraged Rohit to train in the US and then return to India, as he did. Friends of his father's in the US helped him get settled here during the application and interview process. Rohit is currently undecided as to whether he will return to India after his residency. He is unmarried.*

Sachin *(m) is a 1st year internal medicine resident at a large university-affiliated hospital in central California. He pursued a US residency largely out of his interest in research, which he found difficult to pursue in India. He describes himself as "happily unmarried."*

Sagar *(m) is a 1st year internal medicine resident at a large university-affiliated hospital in central California. After beginning to practice medicine in India, he was considering moving overseas for further training when he met his wife—a US citizen originally from India—through Shaadi.com. This sealed his decision to move to the US and pursue a residency position. They have one three-year-old son.*

Sheela *(f) is a 3rd year internal medicine resident at an urban county hospital in California. She had never seriously considered training in the US until her family introduced her to a potential husband who lived and worked in Silicon Valley. Following their arranged marriage, she moved to the US and began studying for her licensing exams. Sheela and her husband plan to return to India after she completes a nephrology fellowship and works as a doctor in the US for a few years.*

Sunita *(f) is a 1st year internal medicine resident at an urban county hospital in California. Her brother, who migrated to the US before her, encouraged her to train in the US, but Sunita was feeling some pressure from her parents to get married after she graduated from medical school. This problem was resolved when family friends introduced her and her parents to a potential husband who was already living and working in the US. She moved to the US following her marriage.*

Vipin *(m) is a practicing physician who moved to the US just under 10 years ago. He practiced medicine in India for a few years, but his parents were specifically looking for a potential wife for him overseas, in order to help him get a visa and pursue a residency in the US or UK. He moved to the US following an arranged marriage to an Indian woman living in the US. Vipin has now completed his internal medicine residency as well as an occupational health fellowship, and he practices part time. He and his wife have one daughter.*

Analysis

When the interview process was complete, a set of fifteen narratives had been collected, from which a number of themes emerged. These themes are organized below in a chronological sequence that roughly follows the path of an Indian medical student to a US residency.

The first section deals with participants' decision to enter medical school. Two different (not necessarily competing) motivations inform this decision: 1) a desire to contribute to society by helping others, and 2) a desire to fulfill family and societal expectations by following a respected and remunerative career path. These motivations persist as dual threads throughout participants' stories, invoking inner debates and informing later decisions.

The next section deals with the decision, during or after medical school in India, to pursue postgraduate training (residency) in the United States. In addition to the "push" and "pull" factors at work in this decision, this section also examines some of the broader social forces that create or contribute to these factors, including transnational communities, the "marriage priority," and the rapid pace of social and economic change in India.

The following section addresses the experience of immigration and application to US residency programs, which is largely a story of challenges, compromises, and sacrifices. For most participants, this phase of their life is one they are happy to have left behind—a sentiment which informs their attitudes about life after residency.

The final section deals with participants' thoughts and plans for the future, as they imagine it at the time of the interview. Here I address the theme of "selfishness" and the internal conflict

between a desire to "contribute" and a desire to achieve one's personal ambitions. This section also includes participants' thoughts about India's future and how it may or may not influence their own. Some participants commented directly on the issue of physician "brain drain" and what might be done about it—their opinions and ideas are included in the final section, as well.

Rather than focusing on each individual case, the analysis is structured around common issues that arose across most or all of the interviews. At the same time, the discussion of these common themes is on a concrete—rather than a generalized—level. That is, it makes no claims as to the meaning or usefulness of these themes beyond the group of physicians interviewed. While it is possible and perhaps likely that some of the same themes would emerge in a larger sample or even a broader population, this analysis is concerned only with a finite sample of fifteen doctors. It is from their experiences that the analysis attempts to make meaning and draw conclusions.

SECTION 1: THE DECISION TO ENTER MEDICAL SCHOOL

The first step in understanding how participants had become medical residents in the US was to find out how they had become doctors in the first place. A logical starting point was to ask how each participant had chosen his or her career. Motivations to enter the medical profession fell into one of two types: familial/social expectations and personal altruistic motivation.

1.1 Family and social expectations

Family and social expectations often arose from familial precedent—the fact that parents or other family figureheads were medical doctors. Alternatively or in addition, there was often a feeling

of parental pressure or an outright directive from parents that their children should become doctors. Such pressures may be understood in the context of a high regard among middle class Indian families for the medical profession, which is perceived not only as prestigious but also as financially remunerative and secure (Mullan 2006).

For some, parental pressures happened to fit with their own natural interests and inclinations. In this sense, they did not appear to feel any conflict or regret around the decision.

> Sagar *(m)*: As for choosing the profession of a doctor, you know, I belong to a family of doctors. My grandparents, my couple of uncles, and one aunt is a doctor. So I was always motivated to this profession.

> Pradeep *(m)*: You know, I liked the fact that [as a doctor] my mother actually took a lot of pride in what she did. And I sort of wanted to do that as well.

Others stated outright that their parents' wishes were contrary to their own, or that it never occurred to them to resist their parents' preferences.

> Priya *(f)*: I don't know what I wanted to be. I think my father always wanted me to be a doctor. Looking back, I think that was the only— In India you do your med school right after when you're eighteen, so you don't have so much of thinking or so much experience knowing what you want to do.

> Dev *(m)*: We are two brothers and a sister—we all went to medical school. So we kind of, you know, there's kind of, in India, the way it is in Indian families, it's not what you really like. I mean if I would really like, I would have been an engineer, but, you know, it's the way—I mean they feed you in your mind, you

know: "You guys have to be doctors".... In fact I joined an engineering school. But I was on a wait list for medical school. So when that spot opened, [my father] said, "You know what? You be a doctor."

Like Priya, others also mentioned the fact that Indian students must decide on a career path at quite a young age. This is the nature of the system: Students take their medical entrance examinations immediately after finishing high school, requiring them to start studying for the exams two years prior. In this sense, for some participants medical school did not feel much like a "choice"—or at least, not a choice they made as mature adults.

For example, Ahmad describes a family vacation during the summer after he graduated from high school (an international school in Kuwait, where his family lived for some time), during which he decided to apply to medical school:

Ahmad *(m)*: I was basically deciding my career during that vacation after I finished my high school. I had some cousins who were in med school, and they invited me over and they showed me around. And when I saw that, to me it seemed like something I wanted to do, something that mattered in the long run.... I really can't pinpoint as to why exactly I made that decision. It's just seeing the condition of the masses over there, and the gratitude that the people had for everything that you do for them, it was just like, it was overwhelming. And it just seemed like something that—it just seemed like something that would fit my life, as in, it would make me feel a little better and, it would give basically a purpose to my life.

1.2 Personal altruistic motivation

For Ahmad, whose father is a doctor, family precedents and pressures were a significant part of his motivation. But he also describes an underlying desire to contribute to society by helping people in need. This is an example of the second type of motivation to enter medical school: a desire to "contribute" or to "do something meaningful" with one's life. Several participants identified this motivation, if only vaguely:

> Pradeep *(m)*: Initially I liked, ah, sort of helping people, that kind of a thing .... I don't think that ever ceases to be a motivation if you are a doctor. I mean if it does, then you shouldn't be anymore.

Notably, Pradeep, Ahmad, Priya, and several other participants who clearly identified family pressures as a motivation to enter medical school *also* expressed the motivation to become a doctor in order to help others. This delicate balance (sometimes an inner debate) between serving others and securing a comfortable life for oneself would reemerge at later stages in several narratives, shaping the arc of doctors' professional and migratory trajectories.

SECTION 2: THE DECISION TO PURSUE POSTGRADUAGE TRAINING IN THE US

All but one of the fifteen participants gave a rich account of various experiences during and after medical school that informed the decision to migrate to the US. Like the decision to enter medical school, these experiences were of two types, or levels. On a somewhat superficial level were those experiences that directly related to medical practice and location—the familiar "push-pull" factors of medical migration. On another level were those experiences, attitudes, and values

that would inform and enable this decision. These experiences were generally more personally and culturally resonant than the first type.

This section begins with an overview of the more superficial or obvious "push" and "pull" factors, identified by participants, which initially attracted them to the US. This is followed by an analysis of personal, familial, and cultural forces at work in participants' lives after graduation from medical school, and how these forces also affected their professional and migratory trajectories.

2.1 Push and pull factors

Reflecting on their experiences in medical school, nearly every participant identified some disadvantages of practicing medicine in India, as well as some perceived advantages of practicing elsewhere (the so-called "push" and "pull" factors of medical migration).

Although none of the participants used the "push-pull" terminology, the factors they identified were remarkably consistent with the theory and its place in the existing literature on medical migration (e.g., Hagopian 2005). These factors were primarily related to financial remuneration, professional opportunities, working conditions, and quality of life for themselves and their families.

2.1.1 Financial remuneration

The issue of pay scales and financial remuneration was fairly clear-cut: Doctors in India simply are not paid as well as doctors in the US, particularly in the public sector. While some

participants pointed out that it is possible to earn a comparable salary working in India (particularly given lower costs of living), to do so requires considerably more effort than in the US. Thus the issue of financial remuneration overlaps, to a degree, with lifestyle considerations.

> Kunjal *(f)*: The way the physicians are paid [in the US], it's amazing.... For the same amount of work I'm doing here and the work I would do in India, I mean the differences are amazing. You cannot believe how different it is.
>
> Rohit *(m)*: If you want to be in medicine, the salaries are not good enough in government. So it's kind of frustrating.... It is frustrating when you come here and see that you can earn double the amount of money for working one fourth.
>
> Sunita *(f)*: You know the residency money [in the US] may be very little, but at least you can live. You can pay your rent, you can pay your bills. You do something. In India you don't even get as much.... That is one of the main reasons that people wanted to move away.

2.1.2 Professional opportunities

Alongside financial considerations, the desire for better professional opportunities emerged repeatedly. The professional opportunities sought by participants took various forms, including further training, research, and vertical advancement.

Those who wanted to pursue any postgraduate training at all found themselves in a very stiff competition for spots:

> Dev *(m)*: It's very hard to get into a postgraduate position in India…. There's a big bottleneck. For every hundred people, you can expect only twenty five to do postgraduate. Unlike US, where things are reversed: for every 100 they have like probably 125 [postgraduate positions], and they then assimilate people from outside. So I wouldn't have been able to specialize into like internal medicine or family medicine or something like that back home. It would have been very hard to get a postgraduate training position. That's why I'm thinking I made a better choice coming here.

> Deepthi *(f)*: The competition back home to get into post-graduation—especially in the field that I wanted to go into, pediatrics and neonatology—is quite high. So it's very difficult to get in on the first attempt. So I thought that this would be a better option for me.

Those with an interest in research also found their educational and professional options limited in India:

> Sachin *(m)*: Unfortunately I think in India the culture for research is not as big. Here [in the US], every training program has tons of research going on. It's not the same in India. I don't blame them, they have 1.1 billion people. All the resources are spent trying to take care of people.

Just as different participants sought different professional opportunities following medical school, the difficulties they encountered in pursuing these opportunities varied. Many participants described a difficult professional culture in India, in which advancement depends on favors, corruption, and membership in inner elite circles. There was a sense that rewards are not

evenly or fairly distributed in India. This makes it difficult to honestly work one's way upward in one's career.

Deepthi *(f)*: I think the opportunities and the availabilities over here are far more. I mean if you want to do research back home, you *have* to have contacts, or you have to, um, you have to be one of, you know, the top people to be able to do it. Because you're not gonna be able to do it if you don't have the resources or the help. You could be just like a normal person doing a research paper, and you could try like a million times to get it published, but it's not gonna happen if you don't have the right people, or if you don't know the right people.... The opportunities you get [in the US] are more than you get anywhere else, basically.

Sunita *(f)*: Here, if you work hard, you can achieve, do something with your life. There [in India], even if you work hard, there's nothing that you do. It's the same, you don't move forward at all. But here there is more opportunity, there's a chance. You work hard, you make something out of your life.... It's not like we don't like to, we would all love to work [in India]. But as I told you the political system is so bad. I mean like, as an honest person if you want to survive there, it's not possible anymore. Because there's bribery at every step. Even for the smallest sort of thing you have to pay such a huge amount, whether that's in the form of money or in the form of something else, but you are expected to pay for everything.

2.1.3 Education and growth

In addition to the desire for financial remuneration and professional opportunities, there was a simple desire among some participants for opportunities to *learn*: They wanted to utilize the best possible facilities and technology that modern medicine has to offer. Some of this learning would be of benefit to the individual, but there was also a hope among some participants to bring what they learned back to India. This was an excellent example of the delicate balance and fine line between the desire for a rewarding and remunerative career and the desire to contribute to the health needs of others.

> Pradeep *(m)*: Most of the stuff, most of the studies that come up with new treatments, new kinds of findings, new ways of diagnosing… are mostly come from the US. And then it sort of trickles down to India, and that's when we start practicing it. So ah, I sort of wanted to be at the forefront of it.

> Sachin *(m)*: So, the thing with me is I came here undecided. I didn't come here thinking that I'm never going to go back. I came here for the fact because I could get some basis in training, some very structured clinical training, a background in research, which I think I developed quite a bit of. I did things that I'd just read in books, I did those in UCLA: Sequencing DNA, PCR, fancy words. [Laughs]. So now I think if I do my residency and fellowship training—fellowship also involves a lot of research—and if I do both of them here, and if I decide I should go back to India, I will be a lot of benefit to Indian society I think…. Because I've had good training, and, I can use this in India to great effect.

> Maya *(f)*: My whole purpose in coming to this country is that, even though I feel clinicals are very strong back home, I think the tests and the treatment options and all the advanced stuff is happening over here [in the US], which you don't get to see a lot in India at all. So I think it just gives you a newer perspective, and you know, it's nice when you can combine everything you've learned here from different worlds and then put them together.

Those participants who came to the US in order to benefit themselves, as well as potentially their country, complicate the "push/pull" model of medical migration. Their remarks demonstrate that they are indeed pushed and pulled by various factors—not only as individuals, but also with an awareness of their own agency and ability to affect broader change through the experiences and opportunities they hope to gain in the US.

2.1.4 Quality of life

Finally, there was the less tangible but equally important factor of "quality of life"—an issue that would arise repeatedly throughout several interviews, as participants discussed their changing values and priorities across the span of their careers thus far. This dimension of the migration decision was often related not only to one's self but one's family—particularly among the women.

> Kunjal *(f)*: The quality of life is definitely better here. I mean if I would have been there, it is totally different. The way the friction in life, daily life, is a lot less here in US. So you can spend more time in constructive, ah, you can conserve your

energy and spend more of your time in doing something more important and meaningful.

Sunita *(f)*: If I decide to practice in the rural areas [in India], the government does encourage you for that. But… it's not as if you're going to be single forever! You'll be married, you'll have kids. Where will your kids go? That's one of the main reasons why no one wants to go there, because the future—if you want to plan your future there, where is the future?.... I mean, when you see so many immigrants around it's like, why are they all here?... I'm sure that everybody has a different story to tell about it, but I think there's something common to all of us. Mostly I think it's just for a better life that everyone's come here.

The push and pull factors identified by participants are informative, if not surprising. They confirm the findings of prior studies, which have shown the ways in which parallel advantages and disadvantages of the destination and source countries respectively influence physicians' migration decisions. It would be overly simplistic, however, to say that these advantages and disadvantages ultimately amounted to the fifteen individual decisions to emigrate presented here. One of the central arguments of this analysis is that push and pull factors are not the whole story. There are larger, more complex, and more deeply rooted forces at work in shaping the narratives of these participants.

2.2 Social forces that enable or constrain medical migration decisions

Focusing on a small and distinct sample population, the analysis now takes the push-pull model one step further: It places "push" and "pull" factors in a context of broader, deeply rooted, sometimes culturally-based forces that also influence medical migration decisions.

Some of these forces emerged in the interviews as attitudes or beliefs that did not themselves constitute *reasons* for leaving India, but which somehow enabled and interacted with the ultimate decision to leave. Some of these attitudes and beliefs seemed to resonate deeply with participants' notions of what it means to be a doctor and how they could best fulfill that role; some related to social norms and expectations of participants' families and communities (i.e., for the most part middle class, educated Indian communities). Other attitudes and beliefs operated at still higher levels, constituting broad social forces in their own right: Specifically, gender emerged as an important social force shaping two divergent trajectories—*linear* and *triangular*—which are introduced and explored further below.

2.2.1 "Good medicine"

One common "push" factor identified in survey-based studies of immigrant physicians is the problem of poor working conditions in the home country (Hagopian 2005). This issue is not included in the above section on push-pull factors, because it evoked from participants a discussion that seemed more complex than merely a complaint about "poor working conditions." The common thread in these discussions was that "poor working conditions" in medicine—whether they exist in a particular hospital or throughout an entire medical system—are not only bad for the doctors; they are also bad for the patients.

Every single participant expressed a longing to practice medicine in a system that was not constantly constrained by poor infrastructure and lack of resources—not merely for their convenience, but for their fulfillment in the role of a physician. They wanted to treat patients with the best possible medical care. This was the promise held up by the United States medical system, for doctors and for patients: the promise of good medicine.

> Pradeep *(m)*: In India, I sort of had this experience lot of times where there should have been something done for the patient and there weren't enough resources available. And the second thing, when there were resources available, they were not affordable. So you could not really get to the point where you know exactly what's causing it and, sort of, be able to institute the right treatment, or the standard of care that you're able to give here [in the US]. We weren't always able to do that back in India.

> Deepthi *(f)*: Back in India, um, neonatology is um—I would say that they're ten or fifteen years behind the US, in terms of the patient care. Taking total parenteral nutrition is not as advanced as it is over here. People don't really implement that. The use of vents, although we do have it, we don't have the resources to have enough numbers of vents. We don't have the resources to really save, you know, 26-weekers or 27-weekers that could potentially have a good outcome if we had those resources.... And the coordination that we have [in the US] with other fields, like for example you have, say, a congenital heart disease, and you have the coordination with neonatology and pediatric cardiac surgery. That kind of coordination isn't there in India. I mean it's coming up, but it's very slow. Over here, you are already ready before the baby is born, you know, you've

coordinated with the different teams and different specialties, that, "You know, we have this kid, and we need your help, and let's do it as soon as possible." Planning before the baby's out, so that you know the moment the baby's out, you have like tat tat-tat-tat-tat, one-two-three-four to do. Back home, it's not that well coordinated. So by the time the kid is out, things are kind of complicated, or the kid becomes infected, and you know, it drags along. So few kids can actually have, you know, a good outcome.

Vipin *(m)*: One time a very bad accident happened [between a car and a train]. People brought the driver and the conductor. I think the driver was badly injured, like he had both femurs fractured and he had lost lots of blood. And there's no quick blood to sustain [him]. So ah, I could, I could still remember that we couldn't resuscitate him. He just died. There's no intubation or anything. Nobody calls a code. There's no code or anything.

Pradeep *(m)*: For example, ah, I was in med school for five and a half years, and ah, we did clinical medicine for better part of three and a half years. And ah, I don't remember a single case diagnosed, a single diagnosis of PE [pulmonary embolism], simply because, ah, we didn't have a CT angiogram there. And consequently, people were just, you know, we never knew. If somebody had DVT [deep vein thrombosis], if they came in with shortness of breath, we would treat them with anticoagulation, thinking that they had a PE. We never really *diagnosed* it.... So that was the thing. That's not the way I wanted to do it.

Later, Pradeep emphasized this point again:

> With limited resources you've got to work with what you have. And I didn't want to work with what I had, so—so I came here.

2.2.2 Evidence-based vs. circumstances-based medicine

The desire to leave India in order to practice "good medicine" amounts to more than India's relative lack of resources and the resultant negative impacts on patient outcomes. Many participants described a more nuanced aspect of the problem: the way in which lack of resources can actually change the nature of clinical practice. In their pre-clinical training, they had been taught medicine according to certain principles—the very same principles taught in Western medical schools, from the very same textbooks. But when it came to applying these principles in the clinical setting in India, they found their hands tied. Instead of practicing "evidence-based" medicine, they were practicing medicine according to what the patient could afford, what diagnostic technologies were available (or more often unavailable), and other constraining circumstances—a formula one participant called "experience-based" medicine, and what might also be called "circumstances-based" medicine.

In the excerpts below, three ideas further shape the notion of "good medicine" and its meaning and significance in participants' narratives. These are: 1) Medicine is the same everywhere, but how you implement it is different; 2) Evidence-based medicine is good for the doctor and for the patient; 3) Circumstance-based medicine—in which doctors have to cut corners or rely on the next-best option—is not "good" medicine.

Rohit *(m)*: [Medicine in India] is kind of the same, I mean it's different and same. The medicine never changes, you know? But how you go about it changes a little bit, because [in the US] you have more of the insurance, more people have insurance, you can order twenty different tests, and then you can see. And out there, it's a little bit different because people have to pay out of their own pocket, so you have to really think and just order a few tests first, and go around it.

Maya *(f)*: Let's say its four medications [that a patient needs], but in reality in India a patient can only afford one medication. So which medication do you choose, right? You're going against guidelines. So that's where your clinicals come in, and you have to decide like what do I think is going to help the patient the most, you know. And there's no insurance-based system in India. It's like whatever medical treatment you get, you're paying from your pocket. And when you go to the county hospitals, the treatment options you get are very very minimal. Because no one can afford to do those tests or those procedures on people who can't really pay a lot.... So that's why it's like you know, even though one would want to practice evidence-based medicine in India, it theoretically looks nice, but practically it's not possible.

Vipin *(m)*: In India like ah, you could read a lot, but when it comes to practice it's totally different. And I know that's always different, between reading the theory part and the practical part.... There's a gap.... But now I think here [in the US], they're trying to narrow that gap, because now that's where the evidence based medicine has come into play. There's no evidence based medicine there.

Sagar *(m)*: Okay, so if you're rounding with Doctor A, and you know, you rounded, and then he gives you ideas and everything, and his ideas and his treatment is based on his experience. There is no evidence-based medicine there. And then when I round with another Doctor B, then he presents and he practices according to his experiences. But there is no evidence for that. And I did find, you know, practicing for myself in such a way, I cannot learn anything, you know? Who to follow? So I found that practicing in India is not evidence based….. So I didn't find myself comfortable in that system, so I just thought that you know, let's explore some other option.

2.2.3 The quality of the doctor-patient interaction

Still another aspect of the "good medicine" issue lay in the doctor-patient relationship, which several participants described as being frustratingly one-sided in India. On the most basic level, their ability to communicate with patients in India was limited by lack of time, as they worked in clinics and hospitals severely overburdened by high patient volume and lack of medical personnel.

Deepthi *(f)*: Over here [in the US], we see, in a clinic, you would see like five patients in five hours. Back home you'd see like a hundred patients in five hours. So the kind of attention you can give the patient, or the kind of treatment you can give the patient differs.

Rohit *(m)*: Yeah, I think we spend more time with patients here [in the US]. Means, you do spend time in India, but there's so *many*, you know? It's crazy.

> Sachin *(m)*: .... Because you have more time with the patient [in the US], you tend to address more issues, know your patient better. And just talking more to the patient you might come up with things that might help you with making him feel better in the long run. I think it's very patient-friendly here. I mean I'm not saying doctors in India are doing a bad job, they're doing a fabulous job with whatever resources they have. But if they had this there, they'd probably do much better.

Participants' frustrations with the doctor-patient relationship in India also had to do with serving a patient population with 1) little-to-no education or literacy and 2) an extreme reverence for and unconditional trust of doctors. These characteristics of their patients led to difficulties in information exchange and an imbalanced distribution of responsibility for the patient's healthcare.

> Maya *(f)*: Patients over here [in the US] know what's going on with them. They know the answers, they know what to ask. But patients in India basically rely completely on you. They have no understanding about what the disease is, no understanding about what their treatment is, and that's basically because the illiteracy rate in India is so high, so people are just very ignorant and they think, "Oh I'll just do what the doctor tells me to do and that's fine." But I think it's really important for patients to be really interactive with their care so that you have better outcomes. The more they understand, the better they'll take care of themselves and comply with their medications.

> Pradeep *(m)*: So the patients [in India] basically trust you with whatever you do, and, I mean they won't question you. Which is not good. Because you need to be questioned constantly for you to be able to make the right decision.

2.2.4 Clinical judgment vs. diagnostic technologies: A counter-argument

Finally, a few participants introduced a twist on the "good medicine" concept, pointing out that greater availability of technology in the US may actually lead to a decline in the quality of clinical medicine. Dev, in particular, argued that the advanced laboratory, imaging, and other diagnostic technologies in the US lead to doctors' overreliance on these tools and under-reliance on history-taking, physical examination, and clinical judgment:

> Dev *(m)*: Medicine is when you, as clinician, think what you are doing and just by history and a complete physical exam reach to a diagnosis. That was what we do back home in India.... Good doctors in India are considered the ones who rely on clinical judgment, less on tests. I mean in US, that's something that has been missing.... I did a better physical exam when I was a fourth year medical student [in India] than I do now. And I think that's part of the system [in India]. The system has been designed to make very limited use of advanced testing and stuff, and be a good clinician, versus in US, where there is a lot of emphasis for objective evidence rather than your own subjective reasoning.

Vipin echoed the same sentiment, which he then illustrated with an example from his first year of residency in the US:

> Vipin *(m):* When I was working as an intern, my [resident] sent me to examine this case, a stroke. And ah, I took some time, like almost 45 minutes or one hour to ask history and do physical exam, and I said, "Okay, this guy has got this particular diagnosis, that's it." [My resident said], you know, "Why did you take so long? You should have done it much quicker, because there's nothing, you know, he's having a stroke and you just, you don't have to examine that much. He's already got a CT scan and there's no point in wasting time!" So, [*laughs*] then I realized, here in US, like, just do a quick history and you just do a quick exam, you don't spend that much examining all of the cranial nerves and all that. Because everything is done. Because we don't get the CT done that quickly, you know, [in India]. You have to examine the patient and then you know, you make a diagnosis and then confirm your diagnosis with CT scan. But here, the diagnosis pops up immediately. In the ER, they do the CT scan and you have already the diagnosis. You're just trying to admit the patient and do further care. You're not trying to diagnose.

Dev and Vipin's stories illustrate some of the variability in the values and perspectives of the study participants, who nevertheless are working toward a common goal of practicing medicine in the US. The notion of what is "good" medicine may be partly personal, partly cultural, and partly institutional (i.e., a concept that is in some ways built into medical education and professionalization). While it would take an additional study to tease out richer meanings and further nuances of this concept, it is useful here as an example of one of the broader forces that shape participants' medical migration trajectories.

While a push-pull model is quite useful for understanding how doctors decide to migrate *at a certain point in time*, push and pull factors do not exist in a vacuum. The concept of "good medicine" illustrates the subtle nuances inherent in a decision to practice medicine in another country, and to work within and to know intimately two different medical systems, with their respective advantages and disadvantages.

2.3 Transnational communities

A critical aspect of the decision to migrate to the US is the environment in which such a decision takes place. The individual must first be exposed to the possibility of international migration before he or she can be potentially "pushed" or "pulled" toward the decision to migrate.

A theme that came up repeatedly was the role of transnational networks and relationships in shaping and/or enabling an individual's decision to migrate. On the simplest level, this was merely a matter of exposure: Participants had classmates, friends, and family members who had gone to the US (or other countries) for a medical residency, and this opened their minds to the possibility. At other times, friends or family members would facilitate some of the logistics of migration—providing helpful advice, places to stay in the US, and moral support through the arduous application process. In various ways, these transnational relationships collectively acted as a bridge between the US and India.

> Sachin *(m)*: I had a couple of seniors who were planning to come to the US. I was still in my second, third year, and they were doing their [final year of medical school] in India. So I spoke to a couple of my seniors, and they were in the process of finding out the whole procedure of coming to the US, so they were

very up with all the things you need to do, how to prepare. And I used to just sit with them in the library and I would hear them discuss about it, then I started getting involved in their discussions.

Aditi *(f)*: At that time what I was, why I was considering that option was because of some other friends, my seniors actually, they were doing USMLEs and they were going to US, and I was hearing that there are pretty good jobs there, that they're paying good…. Ah, and then my brother, who is younger to me, also, like a couple of years, and he was also in the med school, and he was actually more interested. And he was kind of further into and was like pushing me, "Why don't you think about this too and…" And I was like yeah that sounds interesting….

Niel *(m)*: The only guidance for me was [a father of a friend who is a practicing psychiatrist in the US]…. I would call him and he would at times guide me…. I mean it was more of psychological support. You know. I would call him and he would always, you know he would always reassure me, you know? I mean you know when you have nowhere to go and someone tells you don't worry, we're there to help you. I mean that's, that's the kind of support I got. Which was, you know, which was a big deal…. Whenever I would talk to him he would be like, "You know if you need some help, let us know, you can come to us, we're there for you."

Participants made it clear that within their social networks and communities in India, there is nothing particularly new or groundbreaking about the idea of moving to the US, especially for

doctors. Many precede and many will follow; transnational networks are born. Over time, transnational communities develop.

2.4 The marriage priority

In some instances, the influence of transnational networks was more critical at the level of families and communities than on the individual. For example, for participants' parents, the fact that other family and community members already lived in the US made their son or daughter's pursuit of postgraduate medical training there an acceptable, feasible, and negotiable reality, which could fit into other social realities and priorities for that family. One interesting and powerful manifestation is the transnational search for a suitable spouse.

The high cultural priority placed on marriage in India—especially for young women—was discussed quite explicitly in some interviews, and was a widespread underlying theme as participants talked about the events and priorities shaping their young adulthoods. Sunita's description of this phenomenon is the most straightforward:

> Sunita *(f)*: If you see any, ah, any conservative Indian families, they're like, they still think that after a certain age, it's better if women plan about marriage as well. Even my parents were thinking on the same lines, and they were like, "Now that you've graduated, you're 25, and you should think about marriage." .... I think my mom was more intent on getting me married; and, ah, my dad was like a little more, you know, "Take your time, if you're not interested in marriage right now, that's okay, but at least, you know, don't waste your time here and there, not doing anything."

Other participants, mostly women, made similar points as they described the urgency that was suddenly placed upon marriage following their graduation from medical school, and the tricky balance of personal and professional priorities they faced at that time. Many stories of how women negotiated this balance are included later in this section, but one relevant comment from a male participant is included here. When asked whether his parents had had any misgivings about the idea of him moving to the US for residency, Ahmad recalled the issue of marriage:

> Ahmad *(m)*: I think the most important issue was the issue of getting married. Um, their main concern was that if I moved to the US, you know, I'm gonna be busy with getting into residency and making my career, and I'd get really focused on this one particular thing and I would not get married, and that was the main concern. And that still is the concern, by the way. So, just basically getting married and having kids was their main primary concern.

Ahmad's comment is notable for two reasons: 1) His parents are clearly concerned about marriage as a priority that should be considered alongside professional plans. 2) While Ahmad's parents are concerned about the marriage priority, their concern did not end up influencing his professional and migratory trajectory. He came to the US a single man. This is *not* the case for most of the female participants, whose experiences are discussed in detail below.

2.5 The transnational marriage market

A phenomenon closely related to the "marriage priority" is the reality that educated middle class Indian families and communities are increasingly spread out around the globe (Chacko 2007). The arranged marriage system remains quite common in India, although the system now includes

a range of modern variations among the urban middle classes (Chawla 2007; Mullatti 2005). These globally dispersed families and communities comprise the transnational networks through which the search for a suitable bride or groom takes place. Parents and family members often initiate and/or facilitate the search process; their son or daughter typically has some input and even the final say in the "match". The family and the son or daughter may also make use of the internet for this purpose.

Dev's brief explanation nicely illustrates how he was able to utilize a network that was specific to his community but was also accessible to him overseas. This virtual community ultimately connected him to his future wife, also an Indian medical professional working in the US:

> Dev *(m)*: When I came to US I needed a visa, so I started my residency at University of Arkansas where I spent my intern year. And then I got married, and then my wife was originally from California, but she was finishing her dental school in New York.... We met on internet. Well it's not technically internet. There's a marriage site which like all the community uses. *Shaadi*.com. So we met on *shaadi*.com

Among the female participants, five out of seven were married at the time of the interview. All five of these marriages were "arranged" marriages, facilitated primarily by the bride's parents. Below, three female participants describe how their families conducted marriage arrangements. Not only do these excerpts give a sense of the process itself, they are notable for the fact that the women's future husbands were all working and living in the US when the two families contacted each other; the potential groom then flew to India to meet his potential bride, at which time arrangements were finalized:

Sunita *(f)*: I have an arranged marriage. It's like, I mean in India there we still have this arranged marriage system, where, I would say it's like, a part of it is arranged and the other part is my decision. And then it's like, we kind of through our family friends, we kind of got to know my husband's family, and my parents had spoken to his family, or I think his grandparents and my grandparents they knew each other, things like that, I mean it was within the known circles. And then, like I saw that okay, the kind of professional degree that we are looking for, the guy, he has it, and he, he's doing well for himself, and that, we thought okay, well, my parents kind of decided like, why not let them meet each other? At least talk to each other? And if they like it, fine, we can go ahead with wedding plans. If not, fine we'll just drop it. So they kind of gave me a few options. And out of these options I kind of found my husband, we were very compatible, very comfortable. And it wasn't like one meeting, one decision, one—I just spoke to him once and then decided. No. I kind of spoke to him over a few months, and then found that, okay, this is the kind of person that I can live with.

Aditi *(f)*: Actually, it's kind of an arranged marriage. It's through internet. My husband, he met my, I mean my dad had put my profile on something like Match.com; There's a *shaadi*.com in India, and um, he has also put his profile over there, and um they got to know each other, because I wasn't managing my stuff, my dad was helping me do that, so. They interacted first, and I met his parents, and then, um, then he came to India in January in 2005, and we met each other.

> Sheela *(f)*: I think it's a typical Indian way; it was an arranged marriage. My family tried to find out about his family through somebody else, some third person. So I met my husband in my house. We spoke for about thirty minutes, he asked me some questions, then my parents asked me, "Do you like him?" I said—I mean, in thirty minutes how can you figure out if you like somebody or hate somebody? So I said, "Yeah I think he seems nice." And so we spoke for some more time and we were married in a month—so engaged in fifteen days and married in thirty days. And then my passport took some time; my visa took some time. But ultimately in about three or three and half months I was here with him, in this country.

These stories illustrate some of the norms and social processes that influence the life trajectories of young women in India. For these young women in particular, the role of transnationalism in the marriage process is notable. For most participants, membership and participation in transnational communities allowed them to leave India without abandoning their commitment to cultural and family values. In this way, transnational communities created synergies that enabled participants to migrate to the US for medical training. Transnational arranged marriages are just one example of this type of synergy, but it is an important example because it is one that also illustrates the critical role of gender in shaping participants' migration trajectories.

2.6 Linear vs. triangular trajectories

When it comes to the personal and professional paths that participants imagined for themselves after medical school, and whether or not they were able to follow those paths exactly, different

interviews told different stories. Narratives began to take on meaning beyond just "what happened." Participants began to engage in issues such as, "Why did this happen? How did I end up here? What role did I play, and to what degree were my decisions and circumstances under my control?" It is here that the two narrative arcs begin to emerge and to diverge from one another.

2.6.1 Toward a single goal: The linear medical migration trajectory

Some participants, reflecting on their time in medical school, described an emerging dissatisfaction with the life and career they were preparing to enter—a sense that something about it was not right for them. These individuals have been quoted extensively in the preceding sections. They offered anecdotes and analyses to describe push and pull factors; and many of their remarks illustrate a collective desire to practice "good medicine" for their personal and professional fulfillment and for the sake of patients. In short, this group of individuals began looking for a different path, a path that would take them directly out of India and into another country's medical system.

This might be called the "direct" or "linear" path from medical school in India to a US residency. While aiming to avoid broad generalizations, the following analysis argues that this "linear" path was the more typical trajectory among male participants. The male participants generally employed a straightforward, goal-oriented narrative structure to explain how and why they had ended up in the US: They knew where they wanted to go in their medical careers, and they saw a US residency as the best way to get there.

One element of the linear path emerged as these participants explained their decision-making processes around coming to the US. Their decisions were clearly pre-meditated and intentional:

> Rohit *(m)*: Yeah, I was [pretty sure about the decision to come to the US]. Because, yeah my dad studied in Harvard and, you know, I just wanted to come here and just see, like better medical education and advancement and all that.

> Dev *(m)*: I had been visiting my cousins [in the US], And I could—You know, I knew I was smarter than them [laughs].... They were already practicing physicians, and those guys were like—I mean, I would not hesitate to say that in Indian community your kind of level of success is basically measured by the financial success you get out of your career, not really by what your academic or your intellectual achievements are. And those guys were like, each one of them were making like more than a million a year.... And I felt that if these guys can do it, I'm like, you know, I can do it..... You know, I had a plan all laid out even during the second year of my school.... The whole process of having [my school] registered with the ECFMG took one year. And in that one year I was working and I prepared for the exams, and once it got registered I immediately took my USMLEs. So the preparation—I mean the thought process was going on while I was still a medical student.

> Ahmad *(m)*: I basically wanted to get um, a big school on my resume, more or less. I wanted to go to a school where, I don't know something like UCSF or USC or Johns Hopkins. I just, it was a very selfish decision as far as, it wasn't for coming to the US and having like the American dream and all that or whatever. It

was just to get a big university name. Because all my friends who went into computer engineering and business and law, they, right after graduating from high school they went to these big schools and I never had that. I mean not that my school in India was any bad, but it's not the kind of school to raise an eyebrow, you know what I'm saying? I mean it's not a Harvard or Princeton or Johns Hopkins. And the whole reason for me to come here was basically to have a big university to back me up.

Dev and other participants offered clear, career-oriented reasons for why they wanted to migrate to the US, and they described their reasoning with a sense of certainty and purpose. For example Dev says he "immediately" began preparing for the United States Medical Licensing Examination (USMLE) as soon as he could; and he describes a longstanding "preparation" and "thought process" that began while he was still in medical school.

A related element among these linear narratives is the fact that the participants encountered very little resistance from family members, making it easier for them to pursue their goals directly:

Sachin *(m)*: [Describing his parents' reacted to his decision to move to the US for residency]: So they were a little sad obviously, but they always used to tell me that "We know you're going to try for bigger things in life, so we're happy that it works out for you."

Rohit *(m)*: So my parents are always supportive [of my decision to move to the US]. They love medicine, all of them are doctors. So, yeah, they didn't have any problem with med school or my decision of coming here. They're like "Yeah,

why not?" you know. "You can do residency and then you can decide whether to come back or not." So they're really, so, that wasn't even an issue, ever.

Pradeep *(m)*: [My mom] was always supportive of, of what I wanted to do from day one. I mean whenever, when I told her that I wanted to go to the US and do this and, and there was never any kind of ah, of an objection from their side. It was always like, "Okay, if that's what you want to do, that's what you do." Um, and that's sort of always been like, it's always been like that. When I told her I want to go to med school, she was like, "Okay, go ahead."

In light of such unconditional support from their family members—as well as the frustrations they had already witnessed or experienced within the Indian medical system—these participants had the motivation and the confidence they needed to migrate to the US. As the next section demonstrates, female participants used a quite different narrative structure to describe the forces, opportunities and constraints that shaped their path to a US residency.

2.6.2 Creative navigation and triangulation: Women's medical migration trajectories.

A separate set of participants—the five married women in the sample—followed a less direct route to a US residency. For the most part, these women completed medical school with a plan to take their Indian medical licensing examinations, perhaps to obtain a postgraduate residency (if they were lucky), and thereafter begin their medical practice in India. Some completed their licensing exams and were indeed practicing for several months or more before changing course and ending up in the United States. Some obtained extremely competitive spots in postgraduate residencies in Indian medical colleges, in specialties such as pediatrics, or obstetrics-gynecology.

For these women, their eventual "decision" to move to the US was not made independently, for its own sake. It was a decision made in conjunction with other decisions—a navigation of simultaneous circumstances, opportunities, and constraints. The paths they carved for themselves were anything but direct and linear. Instead they are best described as "triangular," because these women navigated three key life components to ultimately end up in the United States: marriage, a medical career, and international migration.

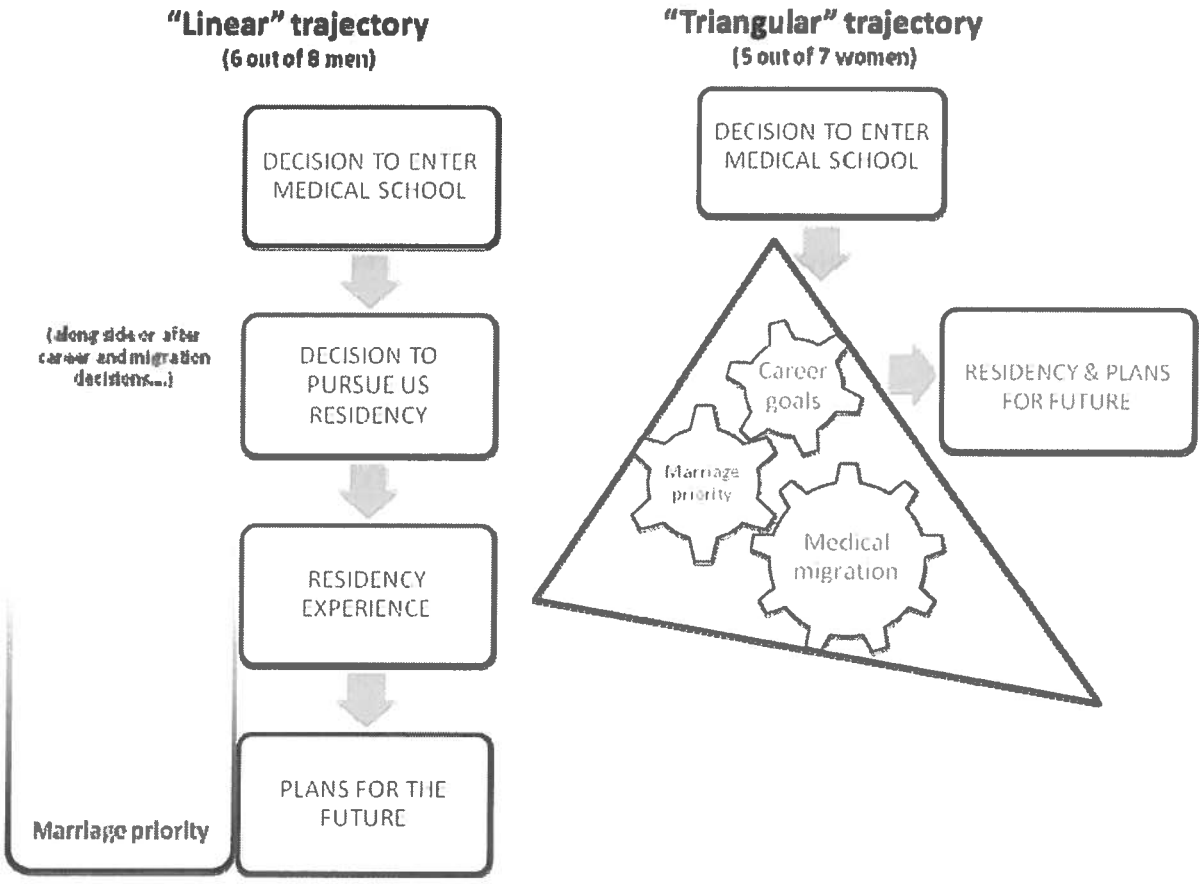

Figure 2: Linear vs. triangular trajectories. 6 out of 8 male participants described a "linear" path to a US residency, by which they directly pursued their career and migration goals. 5 out of 7 female participants described a "triangular" path, which required them to navigate the marriage priority while they negotiated their career goals and international migration options.

The excerpts below illustrate how different women successfully triangulated their career, marriage, and migration decisions. These excerpts illustrate some of the similarities across triangular narrative structures, and they also highlight some of the differences: Some women, such as Priya, did not want to come to the US at all. Priya viewed her migration to the US purely as a sacrifice made for the sake of her marriage. (Priya's triangular trajectory may still be called "successful," however, because she was ultimately able to continue her medical career while maintaining her marriage.)

Sunita, on the other hand, admits to a longstanding desire to migrate to the US for her residency, and she describes how she purposefully used the transnational marriage market to her advantage, navigating parental pressures by triangulating migration, marriage, and her own career goals.

Other women, such as Aditi and Sheela, do not state clearly whether they wanted to come to the US or not; instead, their narratives are notable mainly for their flexibility. For example, Sheela is basically ambivalent about her migration to the US. She never comes down squarely on one side or the other, saying what she wanted or did not want. Instead she says, "I think it was just being like open-minded and knowing why I took this decision, and just trying to stick onto it." This flexibility is a consistent characteristic across the triangular narratives presented here.

First, Priya describes how she ended up in the US after already obtaining a coveted postgraduate residency spot in India:

> Priya *(f)*: So I came with my husband, on his visa. He worked for [General Electric] and he now works for Microsoft, so I came on his visa. I actually didn't want to come to the US, because I knew, my medicine, I had to work harder.... Because I was actually doing post-graduation in India, in internal medicine, and

uh to quit it, to come here.... It's not an easy decision to do. You kind of regret it. But... yeah sometimes you have to do it.

When asked if she regrets the decision now, she replied:

> Priya *(f)*: No, I just feel I would've probably been done. I would have been practicing. Especially when you go through the whole process—many people don't get through the whole process, and probably for them it's like they made a bad choice. For me, because I ended up in residency, and I like where I am, so it doesn't matter now. But it would have mattered if I didn't get into [a US residency].

Sunita (the same participant who earlier described how her parents pressured her to marry when she graduated medical school at the age of 25), describes how she eventually achieved her goal of training in the US, despite her parents' pressures:

> Sunita *(f)*: So after I graduated, I got my medical diploma, I worked for a few months in India, and then, my brother was already here, and he was taking his steps and all that, and he kind of told me that I should kind of consider this option of coming to the US. And that was how I got interested initially. And then I thought okay fine, let me try that. But since my parents were like, "No, you should be getting married also, you should think about that also, not just career," I was like, oh, okay fine, why not combine the two and just get married to someone who is here [in the US]. So that I could come here and also maybe, you know get in residency here and then also probably practice, later. That was how things turned out, and I got married, and then came here.

The key difference between Sunita's narrative and Priya's is that Sunita actually wanted to come to the US to practice medicine, while Priya did not want to come to the US at all—but both ended up in the US *because* of their transnational marriages. Once here, both actively pursued a US residency. In this way, their narratives both represent triangulations of these three key life components: marriage, career, and international migration.

Aditi and Sheela also describe triangular narratives, though they don't express clear desires about migrating to the US or staying in India. Rather, these narratives are notable for their open-mindedness and flexibility:

> Aditi *(f)*: I think I'm here more because of my family. Because I did not make a choice to do my residency here. I mean I came here just because I followed my husband, and I just came here because he's here.... Actually I had at that time no plans to come to US, I was just planning to study more in India. So, when I got married then I had to, um, I came over here.... It was a little bit unexpected for me. I did think about coming to the US when I was in third year in my med school, but at that time I was like more, "Oh I want to be in surgery", but of course during my med school years I forgot that and I was more into pediatrics. So at that time I thought about it. Um, so it wasn't like a complete no-no. I knew that if I want to go, if I end up getting married outside—Because my dad was also looking for a good match for me outside India too, so I had like kind of a thought. So, but I, I was, I don't know, I'm the kind of person who's not really opposed to doing like, studying more, like going back to basics again, so I, I don't know, I think it was little bit hard but I didn't mind so much. I mean, because for me what

was important was that I needed to find somebody who I really like and appreciate in my life, so um, I think that's what I went for. I don't know, at that time my state of mind was, um, whatever's coming in this moment is—that's for me. So I was not really looking ahead too much at that time. It was a bit weird for me, just for me I guess. Yeah. That's what I thought at that time.... I didn't really think too far ahead; I was like, "Okay, if I have to, I have to. But I think if I find somebody who's good, I think I should go for that."

Sheela *(f)*: I met my husband, who is living, who was living here at that time, got married to him, and only then started preparing for the USMLE. Otherwise I probably wouldn't have taken those exams and I probably would have taken Indian exams and stayed there.... When I was trying to prepare, when I was at least thinking about preparing for Indian exams, I had no clue that I'll meet this husband of mine. But when I met him there's also what he told me about all the visa issues. He told me that we may not end up staying in US, which means that there may be a gap in your education, which means that we may have to come back to India. So at that point I felt like, "Hey, I mean, we like each other, so, if it means that I will have a break of one year in between, that's fine." But that didn't mean that I should stop doing something. So, the plan that we came up with was, I'll continue to study, and I mean it's the same study material, right? Medicine is the same. So I'll continue to study, maybe those are different books. So since I know that I'm gonna go to the US, I will read those books; I will continue to prepare and take the exams. If somehow the visa thing works out and I stay here, then great, I'll apply here. If it doesn't work out, then that's fine. But I will know

> that I made this clear decision, that there is a possibility that all my effort may go in vain, but not literally in vain. So I said "Okay, I'll just study. If it works out fine, if it doesn't, then we can come back and start studying for my Indian exams". So I think it was just being like open-minded and knowing why I took this decision, and just trying to stick onto it.

When asked early in the interview how she had come to be in the US, Kunjal replied that she "had to" relocate after marrying a US citizen:

> Kunjal *(f)*: I got married, and like my husband is a US citizen. He was here [in the US] before I came here. So, umm, through family we met each other and got married, and after my marriage I had to relocate myself to United States. So I came to San Francisco, Mountain View, after I got married.

Later in the interview, she admitted that her migration to the US had not been entirely circumstantial:

> Kunjal *(f)*: I will be honest with you. When I was growing up and doing my schooling in India, from tenth grade I would think of ah, like getting more education for me, and getting more opportunity. So I wanted to be here in the US. It's not that I just landed by accident. I wanted to be here since I was in tenth grade, because I had heard a lot about, mm, the, I mean, mmmm, well, there were like, as I said opportunities in medicine, like ah, if you want to do something like um if you want to practice medicine or, I mean, as I told you I wanted to do research, do something meaningful in life. So I would get more opportunities

here, so obviously—I mean I thought of this during medical school also, and I wanted to be here.

Sheela, who talked ambivalently about her move to the US early in the interview, also returned to the topic later and admitted that it was something she had considered long before getting married:

> Sheela *(f)*: I had a lot of my friends who wanted to come here, so I, I did want to come here and study. But it, it's a lot of money. Um, and money is one issue, and also the other part was my parents wanted to make sure that I'm married before I step out of any, step out of the country. So to keep everything in harmony, I just decided, "Hey, Indian exams are much more competitive, and there are excellent hospitals in India. So somewhere down the line, that slight wish that I had that maybe I could come here, that kind of buried and I said okay, I will stay in India. Because of the reasons that I had in the back of my mind. But it did cross my mind.

This shift in Kunjal and Sheela's narratives illustrates that the triangular trajectory is not by any means a passive one. Although Kunjal initially couches her migration in terms of marital commitments, she later acknowledges that she had dreamt since medical school of coming to the US for her own education and opportunity: "*I wanted to be here.*" Likewise, although Sheela initially "buried" her wish to come to the US, she ultimately ended up here by way of her arranged marriage.

Thus the triangular approach was, for some women, a means to achieving the desired end of a medical residency in the United States. In this sense, the triangular path is just as goal-oriented

and self-directed as the linear-independent path: These women knew where they wanted to be; they merely needed a socially acceptable way of getting there. By incorporating marriage into a "triangular" path, they have actively, intentionally, and successfully navigated their way toward a medical career in the US.

Not all five women who migrated along the triangular path stated as clearly as Kunjal what they wanted, but all were highly attuned to the opportunities and constraints within which they were operating as decision-makers. Their key to successful decision-making was to be flexible and adaptive in order to successfully navigate their constraints. The most notable constraint they addressed was the pressure to put marriage *ahead* of their career, or—if they were already married—the familial and cultural assumption that the husband's career should come before the wife's (as Priya's quotation illustrates).

In contrast to the triangulated narratives presented above, in which women's medical migration decisions are significantly influenced by the marriage priority, most male participants addressed the question of marriage only *after* taking concrete steps to achieve their career goals—that is, after securing a US residency. In fact, the topic of marriage rarely arose in interviews with men *until* they began talking about future goals and priorities. Therefore the male participants' comments on marriage are presented in the final section, "Thoughts and Plans for the Future."

2.6.3 Gender as a social force in medical migration: participants' perspectives.

Some participants, rather than merely commenting on their own experience as a man or a woman, made direct observations about the role of gender in the medical migration process.

Sachin, commenting from the perspective of an unmarried man, also remarked upon some important differences he has observed between male and female Indian physicians in the US:

> Sachin *(m)*: Maybe this is just with my friends, a lot of female friends of mine who came here for residency, their parents made sure that they were either hitched with somebody or they're already married before they came here. Because they knew that coming here, getting in here, doing their residency, it's pretty time-consuming. You cannot leave it for after that, and then the girl will be too busy here, and the family will be there, so it's a difficult match then. So I don't know any of my female friends doing my residency at all who have come here trying to get into residency who are as single as I am. They're either engaged to be married, or their marriage is fixed, or they're married. .... Maybe it's a little different. I don't know, maybe [the parents] are scared that, "Oh, how will she fend for herself, then she'll be all by herself."

Priya, although she was not thrilled about migrating to the US in the first place, considered herself lucky to be a woman, because she could rely upon the help and support of her husband throughout the migration and application processes:

> Priya *(f)*: I think it's difficult for men more than for women.... The process can be really tough. For me it was lucky that I was here, and my husband was making money so I didn't have to really worry about all that stuff.

In contrast, Sheela and Sunita both found additional challenges in migrating as a married woman, because they could not devote themselves entirely to the pursuit of a residency. Like the highly skilled women in Purkayastha's study of Indian migrants (2004), Sheela and Sunita described

needing to balance "work and care-work" as new wives who simultaneously hoped to re-start their careers in the US.

> Sheela *(f)*: My husband is—although we are all from the same part of India, culturally we are kind of different. So getting used to his culture, that took some time. Getting used to him—I mean he was a total stranger, right? So getting used to him took some time. And I mean the same was true for him. So those were additional things that were there, that wouldn't have been there if I was not married. But clearly he has been very supportive. So I don't think it hindered me in any ways. But was it different versus somebody who was not married? Yeah, clearly. Because these were some additional things that were going on in my life. They were pleasant, but it was something new. And it, it's a part of life. And clearly for people who were not married, all that they had to do was go home, study, read those books, read those books, read those books read those books read those books. [*Laughs*] And that's it.

> Sunita *(f)*: When I was in India as I told you, I was a completely independent person. But once you are here, you have to depend on somebody for *everything.* And I just think the new country, new life, marriage, new person.... [At home in India] it was like "Okay you want to study now, fine just sit and study." But after marriage, it's not like that. After marriage you're like, okay you want to read books, but it may be day off for your husband, he wants to go out somewhere.... There's a lot of people that think that international graduates, when they come here, they get these good scores because all they do is just sit and read.... But, I mean, for someone like me, who got married and came here, it's like, I'm not

> sitting and reading all day. I wished that happened. And, actually I'm living with this new person here, there's a new issue coming up every day, which I have no clue how to deal with, because I've never dealt with anything like this before. I'm trying to figure out life on my own. With a totally new person, so, and—All these things they take away so much of your emotional time, and mentally they drain you out. So, reading is the last thing on your mind, then. Though it's always your first priority, it's the last thing you're doing in the day. So it's like people think, "Oh, all you have to do is just sit and read, that is what you're doing." But no, that is one thing that is *not* happening, and that is what is so frustrating about it.... I mean, my brother, he came here too, and he came single. And he was doing his MPH then, and the only person that I could emotionally talk to was my brother. But then again he wouldn't understand what I was going through.... He used to be like, "I came to do this too, and I'm working for my own fees, for my own loans, and somebody else is paying for you. Come on, you're having an easy life." Okay it may look easy for you, but I have my own share of difficulties here.... I think it's the same for all the women who come that way, and it's a little different for all the men who come.

The "little differences" that Sheela and Sunita address—such as the differences between being married and unmarried, or the differences between men and women—are precisely the kinds of subtleties which this study aims to illuminate. Whether one is a man or a woman, married or unmarried, from a conservative family or a more modern upbringing, clearly the participants have experienced similar "push" and "pull" factors that have motivated them to pursue a US residency. It is also clear, however, that gendered social forces are at work among this group of

fifteen physicians, further shaping their motivations and influencing the ways in which they pursue their goals.

2.7 Complicating the theory: Overlap between the linear and triangular trajectories

The "divergence" of the two paths proposed above—the linear trajectory and the triangular trajectory—does not represent an absolute, black-and-white difference between the male and the female experience. Of the eight men interviewed, two used "triangular" narrative structures to describe their path from India to the US. On the other hand, two of the seven female participants described their paths to the US as fairly linear: Both had moved to the US alone, for the sole purpose of obtaining a residency position. Both of these women were single at the time of the interviews, with no plans to marry any time soon.

An exploration of these exceptional narratives illustrates why these cases do not necessarily undermine a distinction between the linear and triangular paths as *typically* male and female paths. Instead, they appear to represent variations on a theme of gendered medical migration, reflecting variations in personalities, family structures, values, and circumstances across participants.

2.7.1 Maya and Deepthi

Maya and Deepthi graduated from the same medical school in a relatively large city in western India. Both left India shortly after medical school—unmarried, independently—for the sole

purpose of obtaining a US residency. Thus they appear in many ways to have followed a "linear" path, but their stories reveal a more nuanced—and a more gendered—reality.

Maya has encountered, and continues to encounter, significant resistance from her parents in pursuing her career goals. In this respect, although her path to the US was "linear," it has been anything but direct. It has required her to push back against her parents at almost every step along the way. Notably, her parents' resistance to her career goals has always been tied up with the marriage priority:

> Maya *(f)*: My family, they expect me to marry someone that they want to choose, and their whole thing is that if I went into medicine then there won't be enough guys smarter than me, so I'll have a hard time getting married. So they actually didn't want me to go to med school. So um, I got admission in med school, I told them I'm going, but then they went back to my med school and withdrew my admission. Then I again went back to the med school and I told them to please let me back in, and they did. Then I didn't tell my parents for three months that I was going for med school, they thought I was going for biology [classes] instead or something like that. So it's only after I, you know, got good grades, and then I told my professors to talk to my parents about letting me stay in med school and stuff like that, that they actually agreed to it.

Maya goes on to describe similar resistance from her parents when she wanted to move to the US for a medical residency. Again, she had to fight them with the same single-minded stubbornness that she used to get herself into medical school.

When asked whether she has felt frustrated or angry with her parents for their repeated resistance to her choices and preferences, Maya answered:

> Well yeah, I mean in India it's more like you know that these things exist. So it's not like you hold a grudge or you're like, you know, angry about it or upset about it. It's just more like, "Well this is what the situation is, this is what I have to do, how can I do it?" You kind of already know that you're going to have to face these things, if you want to do something different.

Maya's reasoning typifies the "triangular" model of decision-making that characterizes other female participants' narratives: "Well this is what the situation is… How can I do it?" *How can I navigate this situation and its constraints in order to do what I want to do?* The difference, in Maya's case, is that instead of simply "triangulating" marriage, career, and migration to accommodate her parents' wishes, she pushed back—hard. She has pitted her own will against theirs, and so far, she is winning. She says she thinks that the force of wills may even have shifted in her favor since she moved to the US:

> Maya *(f)*: [My parents used to] tell me that this is what you have to do, and blah blah blah. And now it's like changed, because now they ask me, "So what do you think you want to do?" and, "These are your options, so which way are you going?" They are respecting me a lot more, and they are asking my opinion, which is a huge deal for my parents.

Maya's strong-willed personality seems to have played a major role in paving her path to a US residency. She does not exhibit the same flexibility and open-mindedness as, for example, Sheela and Aditi, whose paths have been largely shaped by the priorities and expectations imposed upon

them by their families. Maya's confrontational approach masks, to some degree, her triangular trajectory. Nevertheless, hers is undeniably another story of the struggle to achieve personal goals in the face of competing, externally imposed priorities.

Like Maya, Deepthi is also single and living in the US on her own. Unlike Maya, however, she has not encountered resistance to this path from her parents:

> *Deepthi (f)*: My parents actually prefer that I finish doing what I want to do, and settle down to a real life before I actually decide to get married, or um, do whatever it is. So for me I've never had that kind of pressure ever. I've never had to face that problem that, "You know, you're 25, you're single, you're not married, you know you need to have a family now, you're growing old, come on start looking at people." Um, I've never had that issue, ever.... They do have a feeling that you know you should start looking, and you should start, you know, thinking about it, but never worrying that you know there's a pressure that you need to get married right here right now. So that's good.

Although Deepthi clearly states she has *not* faced pressures from her parents to marry by a certain age, she refers to "that kind of pressure" as though it's very common. Notably, she uses almost exactly the same language that Sunita used to describe the pressure from her own parents. (Sunita: "Now that you've graduated, you're 25, and you should think about marriage.") It is as though these two women are both referencing a common cultural script, familiar to all young middle class Indian women.

Deepthi goes on to describe almost the exact same phenomenon that Sachin described, in which parents are fearful of letting their grown children move to the US alone. She makes a point,

however, to describe her family as different, even exceptional. In contrast to Sachin, Deepthi's explanation of this phenomenon is strictly gender-neutral: Deepthi says that whether or not parents allow a grown child to move to the US is a matter of family preference, rather than gender.

> Deepthi *(f)*: There are certain families, like there are friends of mine who want to come here and study. But their parents feel that if they send them off on their own over here, they're, um, they're going to, um, they're going to change for the worse. And by "worse," I mean they're going to do things that the Indian families would generally not consider to be ethical, or good, or whatever you want to put it as, moral. So you see all these things, there are certain families that they want their kids to study abroad, but they don't want to send their kids alone, they want to make sure that they're married or that they have like family or something over there, so that changes the experience, that's one thing. Then you have other families who like could care less, you know, "We want you to study wherever or whatever you want to do." So there are those kinds of things."…. So when I say family backgrounds are different so that's, that's what I mean….. My family's not like that. They don't believe in those kinds of things, so. But most Indian families would prefer that their children are married or settled down over here. Um, I suppose they feel that it's safe because they're married to somebody that they know, and is from their same cultural background, and not somebody from this country. So I suppose in that sense they feel that they're safer. You know? That's the only thing that I can understand from it, very honestly.

Although Maya and Deepthi both moved to the US as single women, they both believe that the "general thinking" in "most Indian families" is that a daughter (or according to Deepthi, perhaps a son as well) should be married before moving to the US for her/his residency. In other words, they are each somewhat exceptional in their own way—Maya for her strong-willed resistance to her parents' traditional values and pressures, and Deepthi for her family's unusually liberal approach to her career and marriage priorities.

Despite coming from very different family situations in India, Maya and Deepthi both mentioned that a partial motivation for moving to the US was to gain more financial and personal independence from their families:

> Maya *(f)*: It's just that in India, you're so financially dependent on your parents. It's like, um, in India you can't go and get a job, I mean if you go and get a job people say like, "Oh my god, did you see that that family's daughter is working at this place, they must be having some financial crisis on their hands which is why they've asked their daughter to go work." .... So in that respect it's kind of different, so you know, you never get that feel of financial independence. Because as long as you're dependent on them, you're obliged to do what they tell you to do. You don't have a say in your life whatsoever. And I think a lot of people kind of get frustrated with that, and therefore decide to, you know, move out or you know go to different countries, so you know, they can experience life on their own.

> Deepthi *(f)*: As a resident [in India], the stipend that you get barely compensates for your monthly expenses, so it becomes—most residents are dependent on their parents until they're done with residency. I think the idea of being on your parents when you're like 25 and 26 can be, um, it's rather sad, I feel. So one of the reasons I wanted to come here was, the fact that I can be independent because with what I earn, I can survive. I don't have to be dependent on my parents to have to, you know, to feed me or to pay for my rent or whatever it is. That kind of independence isn't there back home. That's one of the reasons that people leave.

This desire to be financially and personally independent from one's parents is arguably another expression of "triangular" thinking, by which Maya and Deepthi navigate their position in relation to various pressures and constraints. By moving to the US, they have gained considerable leverage against their parents and/or societal pressures (including the marriage priority), giving them even more freedom to make their own decisions.

2.7.2 Vipin and Sagar

Both Vipin and Sagar are married to Indian women who were living in the US *before* the marriage. In this respect, Vipin and Sagar differed from the other six men in the study, who all moved to the US unmarried. But they also different from the married women in the study. Neither Vipin nor Sagar triangulated their marriage, migration, and career decisions in order to make migration more acceptable to their families. Nor did they passively follow their wives overseas and then re-start their careers by applying for US residency positions. Both men knew

that they wanted to pursue a US residency, and they used marriage (at least partially) as a logistical tool to facilitate this goal. Essentially, they explained, if you are an Indian doctor hoping to procure an American visa, it helps to have an American wife.

> Vipin *(m)*: My ambition was I wanted just definitely to study, go abroad and study and just do some specialization. Because ah, way back at that time in India, like ah, there's just limited resources.... So finally [laughs] I, all things came together and then ah, then I came here after I got married....Basically, ah, her parents were looking, and my parents I think were specifically looking for somebody abroad and so that, that would make me easy to go and ah start my career and all that.

> Sagar *(m)*: So actually when I was in my medical school, I was looking for options, different options, you know, what to do next. [I] started working there [in India] as a consultant in a government hospital, and then didn't like it there at all, so....

Sagar went into detail on some of the reasons he didn't like practicing in India, and the reasons he was interested in applying for residency positions in the US. (Some of these quotations can be found in the sections on "push-pull" factors and the desire to practice "good medicine.") Finally, he said:

> Sagar *(m)*: There is a third reason also. The third reason is that also, my wife is from United States. And so um, and so, you know, I met her on internet. [Laughs.] And then you know we started talking, and of course I wanted to explore other options at that point too, but then I started talking to her and I found

> that you know, she's the one for me. And then that also motivated me further to come to United States….

When asked whether he was specifically looking for a wife in the US in order to facilitate the migration process, he said that in fact it was more circumstantial than that.

> Sagar *(m)*: Actually I was not looking for any match or anything. You know how it is in India, parents get involved, and my mother put my profile or whatever on the internet, and she got across that profile. And then my wife contacted me, you know, "Do you want to talk? Are you interested?" And I guess I thought, "Yeah, you know, why not? Let's talk." And then eventually you know, ah, with time, it turned to you know I started liking her and then we got married.

Later he emphasized again that although his marriage "motivated" him to come to the US, it was not merely a means to an end:

> Sagar *(m)*: To go to US was always in my mind, because as I said I was exploring options. So, but [meeting my wife] further motivated me to come down here.

The language used by both men (Vipin's "ambition" of wanting to "definitely" pursue a specialization in the US; and Sagar's thoughts during medical school about "what to do next"), echoes the language used by other male participants: They describe their own ambitions first, and marriage second—almost as an afterthought. ("Yeah, you know, *why not*?") Vipin and Sagar both used marriage to facilitate and even enable their medical migration, but more as a matter of convenience than as a fulfillment of cultural or familial prerequisites.

Interestingly, both Sagar and Vipin mention their parents' roles in the transnational search for a suitable wife. Several other men also mentioned their parents' interest and involvement in this process. For men as well as for women, undoubtedly, the marriage priority is a real social force to contend with, particularly as they face the long and arduous process of medical training. For men, however, the marriage priority is something they considered *alongside* their career goals, including their intentions to pursue a US residency. Indeed, the complete absence of any pressure to place marriage *ahead of* one's career priorities is what links all the men's narratives together. Conversely, with the exception of Deepthi (who seems to acknowledge her family as being unusual in this regard), all of the female participants faced pressure to put marriage *ahead of* their career priorities including medical migration.

While the "exceptional" cases of Deepthi, Maya, Sagar, and Vipin do not on the surface fit the "triangular" and "linear" narrative types, the information they gave in their interviews is consistent with a gendered understanding of medical migration among this sample of Indian physicians.

SECTION 3: THE EXPERIENCE OF MIGRATING TO THE US AND APPLYING FOR A RESIDENCY POSITION

3.1 "You take whatever you can get": Sacrifice and compromise

There is one aspect of medical migration to the US that participants unanimously, resoundingly agreed upon: It requires a significant amount of sacrifice and compromise.

3.1.1 Financial sacrifice

The residency application process—for USMGs and IMGs alike—is extremely costly, with application processing fees and travel expenses amounting to thousands of dollars for most applicants. For applicants coming from a country such as India, the relatively high cost of living in the US is an additional financial burden.

In addition, many participants were unemployed for long periods (or the entire duration) of the application process. During this time, some relied primarily on financial support from their parents. Those who were married were fortunate to be able to rely on their spouse's income, which came in US dollars. Either way, there was a keen awareness among participants that the application process demanded an enormous financial investment for an uncertain return:

> Sachin *(m)*: It's a big financial thing, because the exams like I said they are expensive. Like each step is around $850 dollars. This is for a person who is not making money. So I had to be sure I wanted to do this before I came here, so I did a lot of thinking.... It's going to be a big financial decision. My parents were always there, they were like, "Don't worry about money." I come from a very middle class family, they were very supportive. But then I knew that I couldn't just play around with it.

> Sagar *(m)*: It's ah, it's hard, it's very hard. Especially initially. Initially, you know when I migrated here, initially I was not working. And you know, my wife was working, and you know she, she was taking care of all of us. And ah, it's, and you know, money was not enough, and then we have to you know, apply for applications, and it's a costly process.

3.1.2 Career sacrifices

Another frequent theme was that of sacrificing one's true career interests or goals for the sake of getting *any* residency spot in the US. This problem begins with the extremely competitive application and match process, which several participants described as being unnecessarily and even unfairly difficult for IMGs (as compared to USMGs). Various requirements for foreign applicants—for example, clinical and research experience in a US hospital—proved to be difficult obstacles for many participants.

> Kunjal *(f)*: Here, ah, like in good university programs, they would want you to have research in the United States. So if you have been in India, how can you do research here in US? How can you have US experience if you have just come from India? Or from any other place?

Some participants found that their best hope for fulfilling these requirements and escaping the "vicious circle" was through personal networks—i.e., the Indian immigrant community. ("You have to go through people who are known to you," Priya explained.)

Sagar's story is exemplary. After several frustrating months of searching for a research job, he finally met a doctor at his local Sikh temple who was willing to help him:

> Sagar *(m)*: One of the guys there, who was working in [a local research hospital] helped me to get that position of research under him. Otherwise, I applied so many places for research and I did not have any success. Unless I knew

somebody. I knew that guy, and he helped me out. And that happened within five days. And I applied lot of places and didn't, you know, go through.

Even for IMGs who manage to acquire the necessary US work experience (as all of the participants eventually did), competition for residency spots is extremely stiff, as most programs fill their open spots with USMGs before considering IMG applicants.

Of fifteen participants, twelve matched to internal medicine residencies, one to family medicine, and two to pediatrics. While some participants said that they had always been interested in a career in internal medicine and/or family medicine, several applied for these programs simply because they felt it was their best shot at getting any position at all. The general sense among participants was that even the best qualified IMGs must be willing to make sacrifices and take what they can get if they hope to end up in any residency spot at all.

> Vipin *(m)*: That's one thing, coming to States, I mean, you have to go by your circumstances, of what—You have to sacrifice something. So I really wanted to become a surgeon but I knew… I had to just forget about the route, the path of surgery…. But internal medicine was a good thing that God gave me, and I was happy to accept, okay even though I don't like it, but I had to do it.

3.1.3 Personal sacrifices

The necessity of sacrifice was also evident in participants' personal preferences and considerations surrounding residency programs. Most applied to and ranked programs all over the country in hopes of getting a position *anywhere,* regardless of their preferences for a

particular location. Many were constrained by their need for a visa, which they could only obtain from certain programs. Some accepted a "pre-match" agreement (a binding contract for a guaranteed residency position) even if the program was far from their first choice in location or specialty, fearing that they would fare worse in the regular match process.

Dev's experience reflects all three of these considerations: the need to consider visa issues, the willingness to move to an undesirable location, and the allure of the pre-match.

> Dev *(m)*: When I came to US I needed a visa, so I started my residency at University of Arkansas, where I spent my intern year.... Initially I wanted to do internal medicine. But I had, I was struggling to get an H1-B sponsorship for that program. So not many programs were willing to sponsor me on H1-B visa. Because on a J-1 visa, that is, you have to either go back to your country or you have to be in an underserved area for 3-5 years. And that 3-5 years is not like you work like a normal doctor. There is a lot of exploitation in that whole process, so I wanted to avoid that. So I ended up in a family practice program. They offered me a pre-match position, and they also offered me an H1-B visa, and so that's why I ended up in Arkansas.

The location issue was further complicated when a spouse was involved. For married women (most of whom were initially living with their husbands in the high-tech hub of Silicon Valley, in California), the question of geographic location became, in effect, another site of triangulation. They found themselves attempting to balance their own career goals with their husbands' willingness to move to a different state, or their own willingness to move away and maintain a long-distance relationship. Each of the options required some measure of sacrifice:

> Aditi *(f)*: I looked for the places within California where I can apply, but then I knew that it's hard to get on the west coast. So I ended up applying all over the US, and I did interviews all over. But then I narrowed it down, when it was the time for the match thing. I was so attached to my husband, I was like, I'm not going to, really, go on and interview more.

Kunjal's story is a particularly wrenching one. Although her husband is a Silicon Valley–based software engineer, Kunjal felt that her chances of matching in California were slim, so she hedged her bets and accepted a pre-match agreement at a community internal medicine program in New York:

> Kunjal *(f)*: It was a difficult decision because my husband was in a good job. He's an engineer, he works in Bay Area, and the Bay Area has a lot of engineers. So… he wanted to be there. And if I had to do a residency, I had to move out, because it was really competitive. California was really competitive.

Later, she explained the reasoning that led her to accept the pre-match in New York, and the ironic twist of fate that followed:

> Kunjal *(f)*: We have to take whatever we get. I mean it's being like very blunt and honest, but any program that gives us a pre-match, we would not like to go to a match. Because the uncertainty of the match—like if you remain un-matched, what will you do the whole year? You cannot do anything. So you take whatever program, even if it is not a good enough program, if they offer you pre-match. Like my program, the one where I am, offered me a pre-match. So I did not want to go to the match. And you know what? I matched into USC—USC in

> California. And then I had to tell them I cannot take this position. It's tough. [*Laughs.*] .... So, it's like you, you take whatever you get. I mean to be real honest, this is the fact: Most of the foreign graduates, they would just take whatever they get.

For the fifteen participants in this study, the numerous sacrifices eventually paid off. All are now US residents or licensed physicians. Some spent months or years working in unpaid clinical or research positions, changed fields from their original medical specialty, or moved thousands of miles from their spouses for an indefinite length of time, in order to achieve this goal. All of them spent thousands of dollars on a process that offered no guarantee of eventually securing a residency position.

These years of sacrifice made a profound impact on some participants, influencing their motivations to practice medicine, their attitudes about home, and their thoughts and plans for the future.

SECTION 4: THOUGHTS AND PLANS FOR THE FUTURE

4.1 "Medical training made me selfish": Choices of lifestyle and location

In talking about the future in terms of their personal and professional goals and priorities, several participants said that they are looking forward to a brighter future after residency. Many mentioned specifically that they would be glad to earn a more substantial income and generally have a better quality of life. Some stated more bluntly that they are done making sacrifices; From now on, they're ready to cash in on some of the rewards that medicine supposedly has to offer.

This sentiment is perhaps unsurprising. (It is consistent with recent trends in the attitudes of US medical graduates [Newton 2005]). What is particularly interesting and significant about this attitude among Indian immigrant physicians, however, is that it often relates to their feelings about having left India, and their thoughts about possibly returning there someday.

Ahmad, for example, described his somewhat impulsive decision to enter medical school the summer after high school graduation. ("Just seeing the condition of the masses over there, and the gratitude that the people had for everything that you do for them, it was just like, it was overwhelming. And it just seemed like something that...would give basically a purpose to my life.")

Several years later, at the time of the interview, Ahmad reflects on the challenges that he has endured and continues to endure in his grueling IM residency at a busy community hospital, and he acknowledges that his priorities have shifted:

> Ahmad *(m)*: I'm here working 24-30 hours straight out, and ah, yeah, I think I've made a fair amount of sacrifices. I'm sure people have done bigger things, but for me this is pretty big.... I'm here, living alone in California, um, you know, not keeping in touch, not knowing anybody—I barely know what's going on in the outside world right now. And ah, it's just so many things that, they might not seem like big sacrifices, but they meant a lot to me, and I gave all of it up just to do this. And, yeah, I don't think I'm gonna make anymore compromises after finishing residency.... I think doing my residency and going to med school has made me a little more selfish, I think very selfish. And ah, right now, I hate to say this but I think after I finish my residency, it's gonna be very important for me to

> be happy at the end of the day, because, I mean I'm not, I'm not gonna be one of those sacrificing people who give up everything in their lives just so they can do something for other people. That's definitely not going to be me. My happiness is going to matter the most, and ah, my lifestyle is going to matter the most. So I, I definitely—any decision, anything, any decision I make after I finish my residency is gonna be a very selfish one. It's gonna be focused on me. And if it helps out people, that's awesome, I mean you've got two purposes served by one thing. But if it doesn't, so be it.

Ahmad's remarks are not representative of all fifteen study participants Generally, he expressed more internal conflict about the decisions and sacrifices he has made, and he seemed more anxious about creating a comfortable life for himself after residency. But he is not alone in his desire for a nice lifestyle, nor in his conflict over wanting to help other people but also wanting to help himself. These sentiments emerged in remarks from many participants who emphasized the importance of being financially secure and established in their careers before considering other values and priorities—including the desire to help people in need.

4.1.1 Getting to a "good place"

For many participants, talking about their goals and priorities for the future led them to ponder the possibility of one day returning to India, often for altruistic reasons. Dev explained that is very important for him to return to his village in the future in order to maintain family connections, keep his three-year-old son in touch with his cultural roots, and to "do something" for his community:

Dev *(m)*: I think you know at some point I would go back there, and actually ah, you know, actually try and set up small clinics. I really want to do something for my village, because I've been very distant from it.... I believe we Indian doctors we really would want to give back to the community we came from. We do try to do it, but most part when that happens is , when um, maybe later on, when we are fifteen years into practice, we basically feel now is the time to give back. Because for first ten fifteen years [*Laughs*] you probably are building up four houses, building getting new cars and stuff. So I believe giving back to community doesn't really happen until fifteen years of active practice.

Other participants echo the sentiment that "giving back" will likely have to wait until other priorities are in order. Aditi says that although she and her husband are both eager to do non-profit work in India, this probably won't happen until they are "pretty strong," perhaps five or six years from now. Sheela also says that she would prefer not to return to India until she's had at least a few years to make some money in the US:

Sheela *(f)*: I think I will finish my fellowship, and maybe I will work for a year or two to get the flavor of what it feels like to earn money. Because it's been like, almost, right now it's been ten years of training. I don't see the money that people talk about that doctors make. It's just hard work. Good medicine, we say that "Oh medicine is wonderful wonderful wonderful." But I do think that okay, I do want to know what it means to make money.... So I'm looking at another four, five years.

4.1.2 "You tend to get used to good things faster": Thoughts about returning to India

Although Sheela acknowledges that she would like to earn money in the US for a few years before returning to India, she also says that she will not let the allure of a US salary distract or prevent her from her planned return. The image of the Indian doctor who intends to return to India but, for financial or lifestyle reasons, inevitably postpones his or her return, came up in many interviews:

> Sheela *(f)*: [My husband and I] at this point are really clear about going back. I do hear people saying that "Hey once you start making money you're gonna change your mind, you're gonna stay here." I don't know what to tell them but I'm just gonna say that honestly this is what I feel right now.

Many participants described their first trip back to India as an experience of reverse culture shock, and one which continues to inform their considerations of returning to India permanently one day. One sentiment I heard repeatedly was the idea that after living here for just a few years, it might be difficult to adjust to living in India again:

> Sunita *(f)*: Probably eventually I may want to retire back in India. But then after living here for so many years, will I be able to go back to India? That will be the big question, then. You'll be used to things here, and going from India to here, that was at an earlier age, while you're young, your mind was more open to change then. You can easily adapt to things. But once you're like somewhere in your fifties, things may not be that easy to change. You're not open, as open as you were thirty years back.... Actually this thought struck me when I went back to India for a vacation, after my match, I kind of felt that it was a little difficult.

Because um, three years back, when I was living in India, power cuts weren't a big thing for me. I was like, "Okay, anyway I know that I'll have a power cut from this time to this time." Not having water 24/7 wasn't a problem, because you're used to that. But once you're here, you have water 24/7, in fact you have hot water, cold water, you have power every day of the year. I mean you've taken all these things for granted. Once you go back, then you realize that "Oh my gosh, I can't do anything without all these things!" Then, it kind of came to my mind like, "Just for three years, if I get used to things in such a way, then imagine if I'm living there for *thirty years*, how is it going to be then?"

Sachin *(f)*: So, it was funny because I grew up in India, I spent 25 years of my life in India. And I go back and suddenly it's too crowded, and people honk too much… I have a lot of friends back home in Bombay, so I think it'll always be fun going back and visiting them. But it was a little different, um, you tend to get used to good things in life faster, so, less of traffic, people following rules, so those kinds of things grow up on you faster.

Aditi *(f)*: It's not the same. I think the first time when I went back, I was so used to living [in the US], I was so used to seeing things the way they happen over here….. I used to look at home, "Oh where's the paper towel?" I was so used to using the paper towel here. [*Laughs*] So I mean so many things were different at home than the way things work over here…. So, I think, yeah, it felt like as if things are not the same, as if I had become a different person. And I still feel it's not going to be same, ever.

Later in the interview, reflecting on her own attitude and what she's seen among other Indian immigrant physicians, Aditi said that she thinks it takes perseverance and strength of will to resist the many allures of life US in order to return permanently to India:

> Aditi *(f)*: I think [Indian doctors] just give in to their circumstances in what they have been living through and then what they get used to. They get more used to working here, liking the environment over here, and then they are like "Why should we go back?" And probably they were not satisfied when they were there [in India]. So I think what you need in yourself to be there is, if you have an aim, if you have a good purpose that's something that you can live up to, and you are ready to lose a little bit of your comfort, probably you can go back and be happy there. But if you want everything you're having over here… I think you won't be successful, and I definitely think that you will bounce back to the US.

4.2 Navigating the possibility of return

Of those participants who hoped to return to India permanently, most were women. Of these women, most were interested in returning primarily for family and personal reasons. They missed their parents, their siblings, and their familiar life in India.

> Kunjal *(f)*: Maybe sometime later I would prefer to be in India. Like um, maybe in the later part of my life, when I'm retired and old…. There are a lot of positive things about being here in US. But what I miss the most is the family.

Sheela *(f)*: The main reason is my whole family is there. And I personally think that the social life there is much more enjoyable, just because all my family's there, you get to meet your family members, you get to talk to people with similar kind of thoughts and feelings.

Sunita *(f)*: I just have to wait and see how things are shaping up in the future.... And just to see if my family is still in India, or if they've moved out here. What would I do all alone being in India?

Generally, the women who cited mainly personal and family reasons for considering a return to India were the same women who cited personal and family reasons (i.e., arranged marriage) for coming to the US. These are the women who followed the "triangular" path to a US residency, combining the marriage priority with career and migration decisions. Their attachment to their families and their desire to return home to be with their families one day suggest that the triangulation of marriage, career, and migration—which is necessitated by familial and cultural pressures—depends largely on individual values and temperament. Gender norms are certainly at work, but the variation even within this small sample demonstrates that different women responded to those norms in different ways.

Deepthi and Maya, the two women who migrated to the US unmarried and solely for their own educational and professional goals, are good examples of this variation. Instead of or in addition to citing family reasons for wanting to return to India, they both said that they want to return in order to "expand the knowledge" and contribute to medical progress in their home country:

Maya *(f)*: When I was in India there were always some systemic diseases that would come up that people didn't have a name for .... A lot of the doctors over

there don't know how to work up a patient who has a rheumataologic disease, and that's because there's not enough education about it and there's also not enough, you know, data or lab tests to support what your findings are. So I think it's like really important to you know, take this information back to India and be able to train physicians in, you know, trying to diagnose these cases.... So that [is] the whole purpose of going back to India, to take this with me.

Deepthi *(f)*: If there's any reason I want to go back home, it's only because my entire family is there. That's one of the reasons. And my second reason for going back home, like even if I don't go back home, would be the reason I think I'm doing neonatology is because, um, neonatology back home isn't that advanced as it is out here. So... to share that knowledge, to be able to help improve in India so that there is better care there, in that field. So that would be another reason.

Aditi is an interesting case of a woman who migrated to the US for marriage and would like to return to India, but also specifically rejects the notion that she would return merely to be with her family. Instead, she clearly cites a desire to "contribute further" to health and development in India. Interestingly, this motivation is one which she shares with her husband.

Aditi *(f)*: We are more than happy to go back. If it doesn't happen for some reason, we are still okay with it. But yeah, we do, we both like serving, actually. He's involved in the non-profit stuff, and a little bit I also try and do with him. So I think that's the reason why we are always open to go back to India.... I mean we don't want to go back just for the family's sake.... No. We want to go back for a

> reason, for a purpose. We want to have some plans to contribute further. That would be a reason to go back.

With what appears to be exceptional foresight and self-awareness, part of the reason Aditi chose to marry her husband was because he, as does she, enjoys serving others and giving back to his community. By marrying the man she did, Aditi incorporated this value for service into her triangular path to the US *and* her eventual path back to India.

Only one male participant, Niel, expressed a clear desire and plan to return to India after finishing his residency. His reasons were neither personal nor altruistic; returning to India to work was simply part of his career plan:

> Niel *(m)*: If everything goes well, you know, get a spot in cardiology fellowship, then interventional cardiology fellowship for two years, and then fly to India. It's an eight year plan for me. If everything goes well, happens on time, and I don't screw up.

Among possible career paths in India, he mentions perhaps joining his parents' private practice or working for a private hospital in the major metropolitan city where he grew up. In keeping with his linear trajectory to the US, then, Niel's intended return trajectory demonstrates a freedom to pursue his career objectives with little regard for family pressures or domestic concerns.

4.3 "How long can you postpone it?": Marriage on the linear trajectory

For many of the male participants, including Niel, the question of how and *when* to address the marriage priority remained unanswered at the time of their interview. It is in this phase of the linear narrative, when these men were discussing thoughts and plans for the future, that they began to talk about the place of marriage in their trajectories.

Single male participants were quick to point out that although they were unmarried, they *were* facing pressure from their families to marry. The pressure was perhaps less urgent and stringent than what was faced by many of their female counterparts, but marriage was certainly on their list of things to do during or soon after residency.

Sachin, who describes himself as "happily unmarried," explains that because he is the younger of two siblings, his parents "never thought about" his marriage until he was finished with medical school and considering moving to the US. (His elder sister, also a doctor, is already married; she lives and practices medicine in India.)

> Sachin *(m)*: The thing is, [marriage] was never a topic of discussion, because I was always the youngest in the family. There's just two siblings, so I was always just the kid of the family. They never thought about it.... [Then] I left for the US, and they knew I was too busy getting settled in the US, applying for residency, which is pretty hectic. Even once I got in, they never brought it up. Only when I was leaving for the US, my mom was like, "Oh if you start like, looking for a girl, don't worry about it, we trust your judgment, you'll be okay." So. Which is not very common in India, but it's also not very unusual.... So my parents are not very worried about it. So a couple of weeks back they just tried to drop in this idea, like, "Have you decided what kind of girl you like?" Because they know that

> I'm actively pursuing a career, so they're like, "Oh we can, if you have thought about it, then we can probably try to help you and try to find someone here in India. If not, then, now that you're three four months into residency, whenever you have time, probably try to prioritize and let us know, and we can probably keep an eye out."

The fact that Sachin is a few years younger than his sister may well be a reason why she is married and he is not. Some of the themes that arise in Sachin's interview and others, however, suggest an explanation that is consistent with a more gendered perspective. One theme is that marriage is a decision and an event that can easily be delayed until after the man has secured his career path. Sachin explains that because he is "actively pursuing a career," and because the residency application process is "pretty hectic," his parents have avoided raising the marriage question, or merely "drop the idea." Pradeep's mother is also "dropping hints." It is as though these parents don't want to pester their sons with thoughts about marriage, while the son attends to his career.

A related theme is the role of parents as "helpers" in the search for a spouse, rather than enforcers of social proscriptions (i.e., the marriage priority). Sachin makes the point that his parents "trust my judgment," and Ahmad says his parents are "fine with whatever I do." As they present it, the decision of *whom* to marry has been left entirely up to them. Likewise Rohit and Pradeep assert that they will decide *when* to marry, regardless of "hints" or offers to help from their parents—both have decided that they "don't want to get married" or are "not ready" quite yet.

These themes run consistently through the discussion of marriage by participants on the "linear" path, and they support the idea that, for these unmarried men—in contrast to their female counterparts—the path to a US residency has been uninterrupted and un-hindered by competing priorities:

> Ahmad *(m)*: Right now [my parents] are fine with whatever I do, I mean they're okay with it. With an arranged marriage or just a regular, you know, meet someone kind of marriage. They're fine with either of the things. But they do expect me to get married at least by the end of second year. Which I think is kind of impossible, but I mean I just don't see it happening because of ah, the crazy hours, and I don't want to spend the first few years of my marriage working twenty-four hours in the hospital and coming back home ah, you know, bringing the work back home. So their expectations, as long as I get married soon that's fine by them.

> Rohit *(m)*: They ask me now, and I'm like, "Uh, I don't want to get married, so." [*Laughs*] It's just me, I mean I just don't want to get married right now, so that's me. A lot of people do that, I know a lot of them get married, or come here and then get married, so it's something, it's just my personal thing, I just don't want to get married right now.

> Pradeep *(m)*: Well, so here's the thing, [my mom] hasn't really pressured me until now, but she hasn't really pressured me into anything. Ah, so, but she has started dropping hints. [*Laughs*] So, ah, but you know what, marriage is not really in the cards right now. Maybe another year. I don't know if it's a good idea to get

> married during residency. But then again, the fellowship would be the same and then how long can you postpone it? I don't know. But I am trying to postpone it as long as I can.... You know marriage is a whole different ballgame. I mean it's so much responsibility, and ah, right now I'm—okay let's put it this way: I can work at whatever times I like, whenever I want. If my hospital hours are over, I can stay back at the hospital, finish my research, and then come home. And ah, that probably won't be the same after you get married.... If you are by yourself it's kind of easier... Your time is your own. And not so much once you're married. ... So. It's, I don't know. I'm just not ready for marriage yet. I'm just making up things to postpone it. [*Laughs*]

Pradeep makes an important point that for an unmarried resident, "Your time is your own." His independence in the US, and his decision to protect his scarce time by delaying marriage, contrasts sharply with the experiences of newlywed women who must balance the demands of building a marriage with the demands of applying to residency programs. ("Getting married is very easy, but keeping it afterwards is so much hard work.... I've never worked so hard, for *anything*.") The important role of gender emerges here once again, shaping the medical migration process and its attendant opportunities and constraints.

4.4 "India hasn't lost me yet": Reflections on the brain drain and brain exchange

The final portion of each interview departed from the otherwise unstructured, participant-directed format to specifically address the concept of the physician "brain drain." Participants were asked what, if anything, they had heard on the topic of physician out-migration while they

were in India. They were also asked to share their perspective on this issue now, as immigrant physicians in the US.

This question generally led participants to reflect either on the past (specifically their own decision to leave India for the US) or on the future (anticipating future migration decisions). Whether it was in regards to the past or the future, this portion of the interview often evoked a sense of uncertainty and internal conflict: On the one hand, participants demonstrated an awareness of the geopolitical implications of physician migration from India to the US; on the other hand, they each had personal reasons and explanations for why *they* are in the US at this moment in time. These two sides proved difficult for many participants to reconcile.

4.4.1 Global trends, personal choices

Every participant commented in an informed and insightful manner about the brain drain phenomenon, the forces that drive it, and its implications for India's overburdened public medical system; and many made a point to mention that they had been aware of these issues when they were deciding whether or not to pursue postgraduate training in the US. Ultimately, however, the decision to migrate was a personal one. Feelings about personal agency and autonomy, response to external pressures, and a desire to pursue internal goals directed participants' decisions *despite* their awareness of the problem of physician outmigration.

> Deepthi *(f)*: It is a very very hot topic [in India]. For example I had a conversation with a professor of mine who came up to me and said like, "Why are you going [to the US]? What is there that you can't get back here?" And I said, "Who are

you to stop me from going there? I may go there and I may come back, you know. Or I may go there and stay there, whatever it may be. It's my choice."

Kunjal *(f)*: You cannot change the whole system. I mean you have to be really revolutionary or radically involved into the system and be really brave to just initiate a purpose to do that. Maybe I was not that brave enough…. People opt for an easy way out, that's what I think…. People tend to be a little selfish at this point. You want to go the easy way. You want to have a good life…. I don't know, I cannot maybe express it, but when you're young, like maybe when you're twenty-five, twenty-six, you want to have all your, all the good things in your life. You don't want to wait too long to get results and rewards for whatever you're doing.

Sunita *(f)*: Everything has to start from grassroots level, which will never happen, for many reasons. I mean we're also a part of that system. Even we are a reason why things don't happen. If everybody's moving away, then the government is like, "When everyone is moving away, then why do all this stuff, when they're not even interested in staying back?" And our sort of argument is, "Well if you guys are not even doing anything for us, why even stay back?" I mean if you see it that way it's like, it's the government's fault. Government also can't do much, there's only this much that they can do. It's up to the people, how much they want to do. But then everybody is like "what am I getting in return, nothing, so why do I do?" I mean everybody is starting out selfish, so even you'll be a part of the game.

Ahmad *(m)*: The thing with me is, um, I don't see myself as being someone who's gonna change things. As long as I can make my life be a little more valuable by doing a little bit of things for people here and there, that's fine by me. Even if I was to stay back in India, I don't think I would be, like, I don't think I'd be involved in healthcare, public health and all that. I would just probably work at a private hospital and just try to get through. So um, as far as the brain drain is concerned, on a personal level, I don't think India's lost anything just because I'm here. And um, again, I don't plan on doing big things and changing things. I just want to be part of something which might matter to a few people here and there. As long as that's gonna happen, that's fine by me.

Pradeep *(m)*: There is this certain element of um, I don't know, escapism, I would say? To move out of the place that you do not think is conducive to your kind of, um, the way you thought things should be. So you move to another place, where it is. And what about your own country? And that's a completely legitimate argument. But, ah, at some point of time you've got to decide of what you want your life to be. And um, and how you want things to be for yourself. And you've got one life, and how do you shape it, and what do you want out of it? .... And I would say... the idea is to treat the person, you know. It doesn't matter whether I'm treating somebody there or I'm treating somebody here. And there are millions of doctors everywhere. The question is: Would I be able to contribute more working in India, where I don't like what I'm doing, and I'm unhappy, and would I be able to be a good doctor there, being in state of mind that I am? Or would I be a better doctor if I work in a surrounding that's conducive to my way

> of thinking, and would I be able to contribute more? And I think I would if, I mean, for any field, any line of work, if you're happy with your surroundings, you're happy with the way things are working, you would be able to contribute more. And thinking about it from a global perspective, probably I'm not contributing that much to India. But I'm still doing what I was trained to do.

Each of the above statements clearly demonstrates the speaker's awareness of a broken system, as well as a simultaneous desire to situate him/herself outside of that system. A theme of "selfishness" or "escapism" emerges, along with a tone of self-doubt. ("What about your own country?") This self-doubt is tempered, however, by the recognition that a doctor's job is ultimately one of service, regardless of where in the world that doctor may be.

Pradeep and Ahmad both point out that a doctor's contribution to society can be conceived of on a population level, and on the level of service to the individual patient. They emphasize that regardless of where they practice medicine, they are treating patients who need medical care—although they seem somewhat unresolved about whether this work would be of *more* value in India than in the US. This is just one example of a rationale which participants used to separate the brain drain as a global phenomenon from their own very personal decision to move from India to the US.

Another rationale for separating personal- and global-level decision-making involved the migration trajectory itself. In the excerpts above, Pradeep and Ahmad (who both followed the "linear" path to the US) describe their migration decision as self-directed, informed, and intentional. On the other hand, women physicians who had "followed" their husbands to the US sometimes used this as an explanation or an excuse for their migration.

> Aditi *(f)*: I do see that [brain drain] phenomenon happening, and I think it is happening at a much greater scale now than it used to happen earlier. And definitely it's very scary. And ah, I'm definitely not in the favor, and I shouldn't be when I'm myself sitting over here. But I think I'm here more because of my family. Because I did not make a choice to do my residency here. I mean I came here just because I followed my husband, and I just came here because he's here. And he was open-ended going back, so I was more comfortable marrying him than not marrying him, so.
>
> Kunjal *(f)*: Here it was like okay, I got married, I had the opportunity, I came here. I started all over again, but [*pauses, laughs*] I don't know. It's like um, it's difficult to say.

In the triangular trajectory, it is perhaps more difficult for both participants and observers to distinguish between individual motivations to migrate (whether they are personal, professional, or both) and the larger structural factors (such as transnational communities and the marriage priority) which may simultaneously or separately enable or impel that decision. In this sense, among female physicians in particular, what appears on the surface to be "medical migration" may in fact be a much more complex phenomenon. The women in this study clearly are not "passive" migrants, as they all took active steps to continue their medical careers in the US and are now important contributors to the healthcare workforce. Yet three of the five married women explicitly pointed out that their migration was not entirely their "choice."

Whether they explain the migration decision in terms of professional goals and personal intentions, or whether they cite familial and societal priorities as distinct from personal "choice,"

all participants in some way separated their individual migration decision from the "macro" phenomenon of Indian physician migration. None of the participants denied responsibility for the decision. Instead, the presiding sentiment among this group of physicians seemed to be, "I'm young. I'm trying to build a life for myself. I care about India and the future of its medical system…. But is it my top priority? No. Can you blame me?"

4.4.2 India is changing rapidly

Regarding the brain drain, one topic that arose frequently was the dynamism of Indian society and the Indian economy. Generally, when participants talked about India's rapid pace of change and development, it was with a tone of optimism and possibility. These changes, they said, might one day open the same kinds of opportunities in India that are now available only in the US. Some even saw themselves as potentially participating in and contributing to such change:

> Kunjal *(f)*: When I was growing up, the brain drain, people wanted to come to US. But as the trend of lately, people are also having good life in big cities in India. Like it's equivalent to life here. They are being paid, not as well as here, but they are being paid really good, and they are having all the development going on…. But um, I don't know about the brain drain, it is like, it is still there. It is still there.

> Deepthi *(f)*: I feel there is a lot of power in that population, very honestly. There is a lot, an immense power to make that change. I think in the last couple of years the trend is—usually the trend was to go abroad and to stay abroad because you

settled down and you had a family and stuff like that. The trend now is to settle back home, you know? If you come with those degrees and that knowledge and everything, and most people, I've seen others have set up their own practice or they go into private hospitals where they're given the freedom to do or make changes as they please.

Aditi *(f)*: I think [my time in the US] will influence me for good; I don't think it would influence me for any wrong reasons. I think whatever I like over here, when I see something different which I've not seen before, or something which is a new way of working things, I feel like, you know, "Oh wow! What if I can just go back and tell my attending over there, "You know Sir, we can do something like this over here, too, and this would be really good for the students over here, this would be good for the doctors over here, this is good for us to learn too," you know? So these are the thoughts that come to my mind when I learn something nice over here, that I should, I should go back and I should just spread it. I should just tell them. So I think if I go back, I would be contributing in a good way. I mean I think I am a changed person, so I think I would be bringing back something more, and that would be for good.

Maya *(f)*: A lot of my friends, including me, I mean we would definitely go back to India to you know, kind of expand the knowledge… There shouldn't be really any issues you know, "Well our country has these many doctors and your country has those many doctors." It's like you know, everything is kind of becoming one whole big medicine practice.

Sachin *(m)*: The thing with me is I came here undecided. I didn't come here thinking that I'm never going to go back. I came here for the fact because I could get some basis in training, some very structured clinical training, a background in research, which I think I developed quite a bit of. I did things that I'd just read in books, I did those in UCLA: Sequencing DNA, PCR, fancy words. [*Laughs*] So now I think if I do my residency and fellowship training, fellowship also involves a lot of research, and if I do both of them here, and if I decide I should go back to India, I will be a lot of benefit to Indian society I think.... Because I've had good training, and I can use this in India to great effect.... There's always a need for somebody to come in and start their own project, and see how things go. So I think ... India hasn't lost me yet.

Conclusions

The aims of this exploratory study are not merely to describe the experiences of Indian immigrant physicians in the US, but to draw from these experiences hypotheses for further studies. Future research may then be used to inform policy decisions surrounding medical migration and global healthcare workforce distribution by national and international governing bodies.

The non-generalizable conclusions from this study are presented here as hypotheses for further research. Like the analysis, they are organized according to the chronological steps of an Indian physician's medical migration to the United States.

1. The decision to enter medical school

For young men and women in India, the initial decision to enter medical school is primarily motivated by family influences and personal motivations.

1) Family influences often arise from precedent (i.e. parents and other family members in the medical profession), although non-physician parents may also guide or direct their children into the medical profession. Previous studies have illustrated the high social prestige of physicians in India, where medicine is both a respected and remunerative career (Mullan 2006). Although study participants did not explicitly address the societal value placed on doctors in India, their descriptions of family-level values and expectations were consistent with this observation. *("The way it is in Indian families, it's*

not what you really like.... They feed you in your mind, you know: 'You guys have to be doctors.'")

2) Personal motivations, where they are strong, often center around the desire to "contribute" to society or help people in need. *("Helping people.... I don't think that ever ceases to be a motivation if you are a doctor.")*

Where these two motivations coexist for a given individual (which they often do), they are sometimes in competition with each other. At the very least, the physician must continually balance these two motivations as he or she makes further personal and professional decisions. Therefore, as India and other developing countries attempt to shape doctors' career decisions to promote development and public health, they must attend to the cultural and familial values that influence these decisions from the very earliest stages.

For example, it may be possible to identify, upon matriculation to medical school, students who cite altruistic reasons as their primary motivation for becoming a doctor. This cohort of students might be studied (compared to a control group) to determine whether and how such motivations impact subsequent career decisions, including decisions about migration. It would also be interesting to observe whether and how these students triangulate their altruistic motivations with external influences.

2. The decision to migrate to the US

Participant narratives are consistent with previous studies, which have found that the decision to migrate to the US for medical residency is based largely upon "push" and "pull" factors.

Participants commonly cited these factors (including financial remuneration, professional opportunities, education, and quality of life) early in the interview, and several emphasized that these are common reasons for doctors to leave India to train and practice in developed countries.

These factors do not exist in a vacuum, however. Medical migration is further influenced, enabled, and constrained by larger social forces. In the case of India, during the time of life when young doctors are graduating from medical school, relevant social forces include transnational communities, family influences (particularly the marriage priority), and the rapid pace of social and economic change in the country.

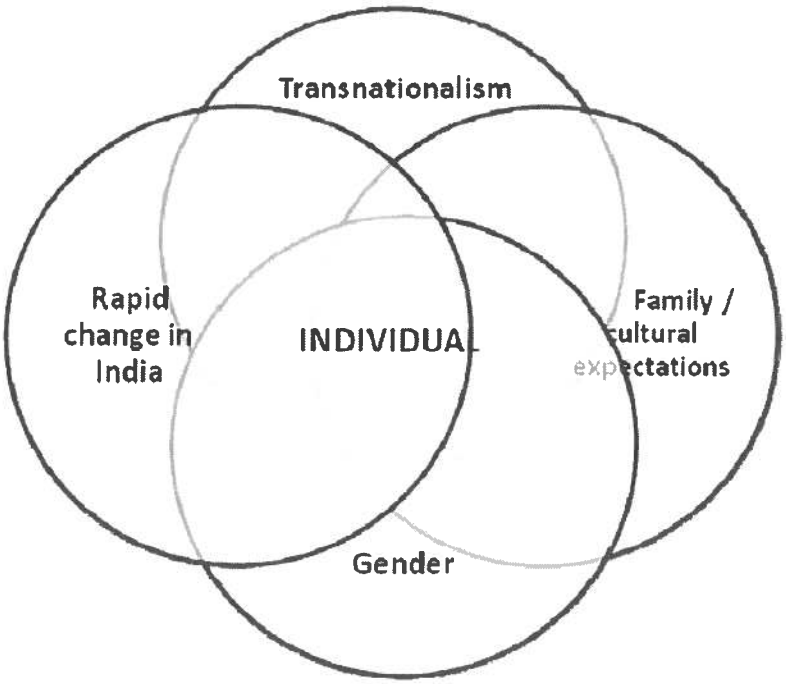

Figure 3: The individual experiences "push" and "pull" factors within a confluence of broader social forces. These forces may ultimately enable or constrain medical migration.

Medical migration as a gendered social phenomenon

A gendered perspective of migration recognizes that gender norms influence and are influenced by all social forces. As such, medical migration must be understood as a gendered social phenomenon, influenced and intertwined with other gendered phenomena in Indian society, including the marriage priority. Some gendered social forces identified among the physicians in this study can be used to draw conclusions about their experiences:

1) Both men and women are encouraged and/or pressured to prioritize marriage during young adulthood. Men may consider the marriage priority *alongside* or even after career goals, but women usually are pressured to place the marriage priority *ahead* of career goals. (*"My parents were like, 'No, you should be getting married also, you should think about that also, not just career.'"*)

2) Because of this different ordering of priorities, men who wish to migrate to the US in pursuit of a medical residency may do so independently and directly; whereas women may need to creatively navigate the marriage priority and coordinate it with career decisions, including the decision to migrate to the US. (*"Why not just combine the two and just get married to someone who is [in the US], so that I could come here and also maybe get in residency here...?"*)

3) Among Indian immigrant physicians, whose career and marriage decisions are often heavily influenced by familial and social pressures (e.g., marriage), the term "medical migration" may often be overly simplistic and thus inadequate for a meaningful sociological understanding of migration patterns. If social scientists consider it important to identify an individual's reasons for migrating and his or her role in a migration system,

then a more nuanced understanding of the overlap and triangulation of such roles is needed—certainly for Indian physicians and likely for other immigrant groups as well.

Balancing service and "selfishness"

As in the decision to enter the medical profession, a balance between the desire for a rewarding and remunerative career and a desire to contribute to the health needs of others emerges in the decision to migrate to the US. This balance is illustrated by two important examples:

1) Participants' comments revealed their desires to practice "good medicine", i.e. medicine that is evidence-based, patient-centered, and not infringed upon by lack of resources. This is not simply a desire for more convenient or more comfortable working conditions. Instead, the value of "good medicine" includes a desire to participate in a medical system that is optimally functional for both the doctor and the patient. *("[In the US] if a patient needs it, he pretty much gets it. Not so much [in India].... That's not the way I wanted to do it.")*

2) The educational benefit of training in the US medical system may be used by immigrant physicians for individual benefit as well as for the benefit of India. If the physician is motivated to share this experience and knowledge with Indian colleagues, then the decision to migrate to the US is not entirely a "selfish" gain for the doctor; nor is it necessarily a "loss" for India. *("I've had good training, and I can use this in India to great effect.")* Although participants raised the idea of "brain exchange" in various forms (e.g. implementing coordinated neonatal care in Indian hospitals, improving rheumatology curriculums in Indian medical schools), none of the participants were

participating in such exchanges at the time of the interviews, nor had they taken concrete steps to do so.

3. The experience of migrating and applying for a US residency

Despite a longstanding and demonstrated need for IMGs to fill domestic physician shortages, the current system operates in such a way to constrain—rather than to encourage—foreign applicants who pursue a US residency. Participants described sacrifices and compromises such as working without pay to gain US hospital experience, changing medical specialties in order to have a better chance at a residency position, and taking a pre-match position across the country from a spouse. Some participants reported that being forced to make such sacrifices has shifted their future priorities toward more "selfish" concerns (establishment in one's career, accumulation of wealth) and away from more altruistic motivations (i.e. service to needy populations). *("They might not seem like big sacrifices, but they meant a lot to me, and I gave all of it up just to do this.... I hate to say this, but I think after I finish my residency, it's gonna be very important for me to be happy at the end of the day.")*

This raises the possibility that a more IMG-friendly system—one that affords qualified foreign applicants a more competitive status in the residency "match" process—might foster more altruistic motivations and enable less "selfish" decision-making, presumably with better outcomes for global public health.

4. Planning for the future

As with the initial decision to enter medical school and the decision to migrate to the US, the decision of whether to return to India often encompasses a balance of personal, familial, and societal motivations. These motivations also appear to be influenced by gender:

1) Just as women often "end up" in the US by triangulating family pressures with career and migration decisions, they more often cite family and personal reasons as motivations to return, compared to men. *("There are a lot of positive things about being here in US. But what I miss the most is the family.")*

2) On the other hand, unmarried male doctors have more time and energy to commit to their careers and professional development once they are in residency in the US. In the interviews, this was reflected in a more career-centered discussion of future plans, which was not constrained by the presence of a spouse and children, and which was less nostalgic for family left behind in India. *("If you're by yourself it's kind of easier.... And not so much once you're married.")*

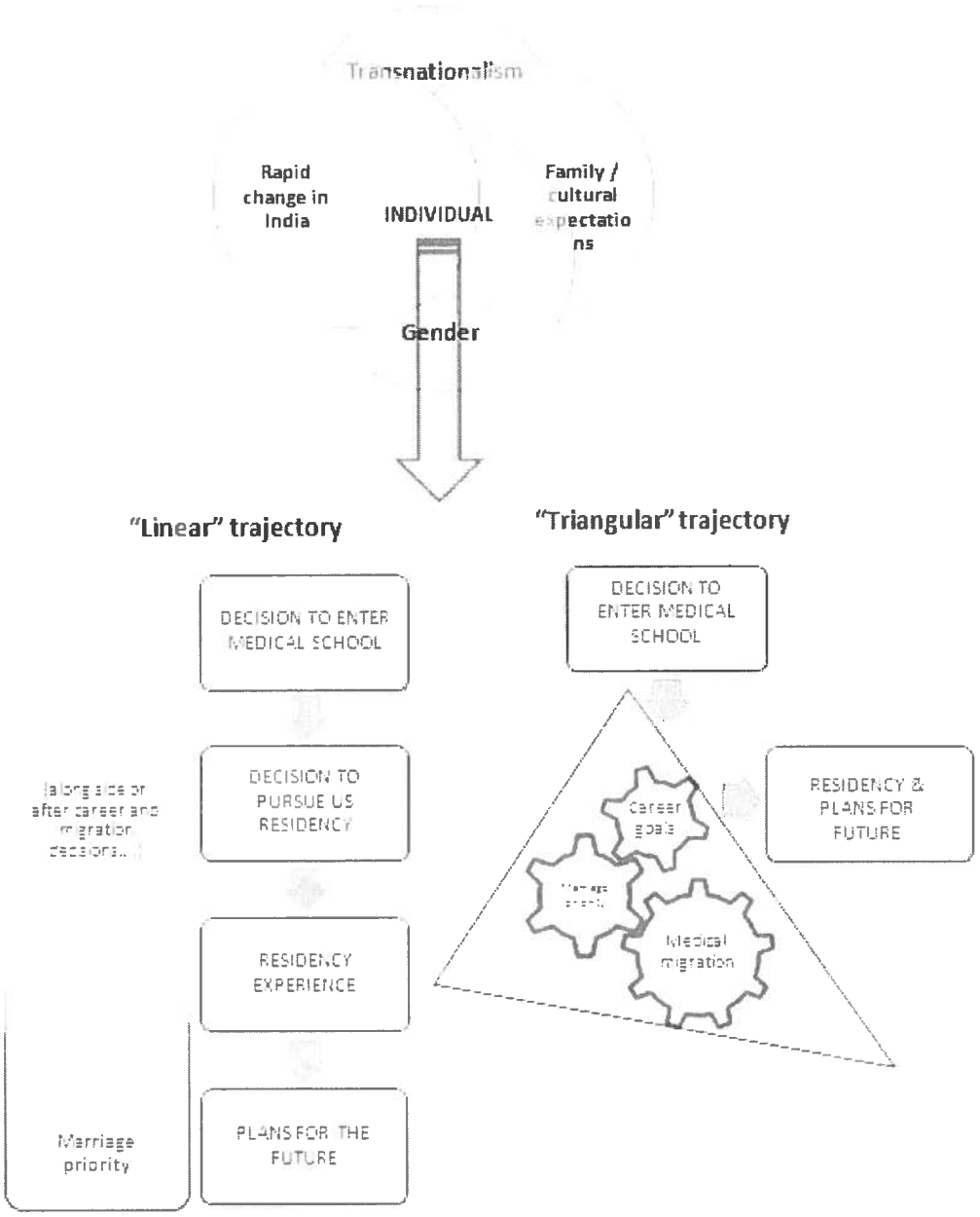

Figure 4: Summary of social forces and their relationship to an individual's decision to pursue a US medical residency, following either the "linear" or "triangular" trajectory.

5. Summary

As illustrated in the above figure, this study argues that the "push" and "pull" factors influencing Indian physicians' migration decisions do not exist in a vacuum. Rather, these factors are influenced by larger social forces, including gender, transnationalism, rapid pace of social and economic change in India, and family and cultural expectations. These forces enable or constrain decision-making in important ways that may not be captured in the "push-pull" model of medical migration.

An in-depth examination of gender and its associated norms in Indian society—particularly around marriage and family—demonstrates the ways in which gender can shape the context of the medical migration decision. Because marriage, particularly for young women, may be prioritized ahead of career decisions, female doctors may be forced to "triangulate" their professional goals and migration decisions with the marriage priority. In contrast, men are free to pursue medical migration with a more direct or "linear" approach, as they address the marriage priority alongside or even after career decisions.

Policy-makers who seek to influence doctors' migration decisions should take a gendered approach to understanding the social forces that underlie it. As increasing numbers of female Indian physicians are migrating to the US (whether primarily as wife, as doctor, or both), it is no longer realistic to view medical migration as a purely geographic, economic, or professional decision. Accordingly, "brain drain" interventions should be strategized along dimensions that encompass a range of personal, professional, familial, and cultural motivations, which influence the decision to leave the home country, the experience in the medical system of the destination

country, and, finally, the decision of whether and how to contribute to the home country in a way that is consistent with personal motivations, familial expectations, and population needs.

Bibliography

Abbasi K. (1999). The World Bank and world health: Focus on South Asia—II: India and Pakistan. *British Medical Journal, 318,* 1132-5.

Akl E.A, Maroun N., Major S., Afif C., Chahoud B., Choucair J., et al. (2007). Why are you draining your brain? Factors underlying decisions of graduating Lebanese medical students to migrate. *Social Science & Medicine, 64,* 1278–1284.

American Medical Association. (2010). International medical graduates in American medicine: Contemporary challenges and opportunities. http://www.ama-assn.org/ama1/pub/upload/mm/18/img-workforce-paper.pdf. Accessed Online October 10, 2010.

Association of American Medical Colleges. (2007). Record number of US medical school seniors apply to residency programs: match participation by international medical graduates continues to rise. http://www.aamc.org/newsroom/pressrel/2007/070315.htm. Accessed November 12, 2009.

Astor A., Akhtar T., Matallana M.A., Muthuswamy V., Olowu F.A., Tallo V. et al. (2005). *Social Science & Medicine 61,* 2492–2500.

Bajaj V. (2010). "India's Economy Accelerated in Quarter." *The New York Times.* Published online, August 31.

Basch, L.G., Glick Schiller N., & Szanton Blanc C. (1994). *Nations Unbound: Transnational Projects, Post-Colonial Predicaments and Deterritorialized Nation-States.* Amsterdam: Gordon & Breach Science Publishers.

Chacko E. (2007). From brain drain to brain gain: reverse migration to Bangalore and Hyderabad, India's globalizing high tech cities. *GeoJournal 68,* 131-140.

Chawla D. (2007). I Will Speak Out: Narratives of Resistance in Contemporary Indian Women's Discourses in Hindu Arranged Marriage. *Women And Language, 30(1),* 5-15.

Cooper R.A. (2005). Physician Migration: A Challenge for America, a Challenge for the World. *The Journal of Continuing Education in the Health Professions, 25,* 8–14.

Dumont J., Martin J.P., and Spielvogel G. (2007). Women on the Move: The Neglected Gender Dimension of the Brain Drain. Discussion Paper No. 2920. Berlin: Institute for the Study of Labor.

Frankel R.M. & Devers K.J. (2000). Study Design in Qualitative Research—1: Developing Questions and Assessing Resource Needs. *Education for Health, 13(2),* 251–261.

Glick Schiller N. & Fouron G. (1999). Terrains of blood and nation: Haitian transnational social fields. *Ethnic and Racial Studies, 22,* 340-366.

Hagopian, A., Ofosu, A., Fatusi, A., Biritwum, R., Essel, A., Hart, L. G., et al. (2005). The flight of physicians from West Africa: Views of African physicians and implications for policy. *Social Science & Medicine, 61,* 1750–1760.

Harvey WS. (2008). Brain Circulation? British and Indian scientists in Boston, Massachusetts, USA. *Asian Population Studies, 4(3),* 293-309.

Harvey WS. (2009). British and Indian Scientists in Boston Considering Returning to their Home Countries. *Population, Space, and Place, 15(6),* 493-508.

Kaushik M., Jaiswal A., Shah N., & Mahal A. (2008). *Bulletin of the World Health Organization, 86(1),* 40-45.

Knox R. (2007). "India's Doctors Returning Home." National Public Radio. http://www.npr.org/templates/story/story.php?storyId=16774871 (accessed December 8, 2007).

Lee E. (1966). A Theory of Migration. *Demography*, 3*(1),* 47-57.

Levitt P. (2001). *The Transnational Villagers.* Berkeley and Los Angeles: University of California Press.

Levitt P. & Glick Schiller N. (2004). Transnational Perspectives on Migration: Conceptualizing Simultaneity. *International Migration Review, 38(145),* 595-629.

Levitt P. & Jaworsky N. (2007). Transnational Migration Studies: Past Developments and Future Trends. *Annual Review of Sociology, 33,* 129-156.

Levitt P. & Nyberg-Sorenson N. (2004). The Transnational Turn in Migration Studies. *Global Migration Perspectives No. 6,* October 2004. Global Commission on Migration.

Ley D. & Kobayashi A. (2005). Back to Hong Kong: return migration or transnational sojourn? *Global Networks*, 5 (2). 111-127.

Leon L.R., Villar H., Leon C.R., Psalms S.B., & Aranha G. (2007). The Journey of a Foreign-Trained Physician to a US Residency. *The Journal of the American College of Surgeons, 204(3),* 486-494.

Medical Council of India. 2009. Medical college data. http://mciindia.org/apps/search/show_colleges.asp (accessed November 12, 2009).

Mehta, R. (1970). *The western educated Hindu woman.* New York: Asia Publishing House.

Mullan, F. (2005). The Metrics of the Physician Brain Drain. *New England Journal of Medicine, 353,* 1810-8.

Mullan, F. (2006). Doctors For The World: Indian Physician Emigration. *Health Affairs, 25(2),* 380-392.

Mullatti L. (1995). Families in India: beliefs and realities. *Journal of Comparative Family Studies, Special Issue: Families in Asia: Beliefs and Realities, 26(1),* 11-25.

Najouks D. (2009). "Emigration, Immigration, and Diaspora Relations in India." Migration Information Source. Migration Policy Institute, Washington D.C. http://www.migrationinformation.org/Profiles/display.cfm?ID=745. Accessed November 12, 2009.

Nandakumar S. (2004). *What's Up Doc?* New Delhi: Parity Paperbacks. Cited in Mullan 2006.

Newton D.A., Grayson M.S., & Thompson L.F. (2005). The Variable Influence of Lifestyle and Income on Medical Students' Career Specialty Choices: Data from Two U.S. Medical Schools, 1998–2004. *Academic Medicine, 80 (9),* 809-814.

Pessar P. & Mahler S. (2001). Gendered Geographies of Power. *Identities*, 7(4): 441-459.

Pessar P. & Mahler S. (2003). Bringing Gender In. *International Migration Review*: *Transnational Migration: International Perspectives*, *37(3),* 812-846.

Portes A. (2003). Conclusion: Theoretical Convergences and Empirical Evidence in the Study of Immigrant Transnationalism. *International Migration Review*, Vol 37, No 3, pp 974-92.

A. Portes & Walton J. (1981). *Labor, class and the international system*. New York: Academic Press.

Purkayastha B. (2005). Skilled migration and cumulative disadvantage: the case of highly qualified Asian Indian immigrant women in the US. *Geoforum 36,* 181–196.

Radhakrishnan S. (2008). Examining the "Global" Indian Middle Class: Gender and Culture in the Silicon Valley/Bangalore Circuit. *Journal of Intercultural Studies, 29 (1),* 7-20.

Rao N.R., Rao U.K., & Cooper R.A. (2006). Indian Medical Students' Views on Immigration for Training and Practice. *Academic Medicine, 81(2),* 185-188.

Ravenstein E. (1889). The Laws of Migration. *Journal of the Royal Statistical Society*, *52(2),* 241–305.

Rayaprol, A. (1997). *Negotiating Identities: Women in the Indian Diaspora.* Oxford: Oxford University Press.

Regional Office for Southeast Asia (SEARO). (2009). National Health System Profile: INDIA. World Health Organization, Geneva.

Riessman, C.K. (2007). *Narrative Methods for the Human Sciences*. New York: Sage

Robinson V. & Malcolm C. Peopling Skilled International Migration: Indian Doctors in the UK. *International Migration, 38,* 89-108.

Saxenian A. (2006). *The New Argonauts. Regional Advantage in a Global Economy.* Cambridge, MA: Harvard University Press.

Saxenian A. (2000). "Back to India: Indian software engineers are returning with enthusiasm and entrepreneurial know-how." *The Wall Street Journal: Technology Journal Asia.* January 24.

Sharangpani M. (2010). Browsing for Bridegrooms: Matchmaking and Modernity in Mumbai. *Indian Journal of Gender Studies, 17(2)*, 249–276.

Syed N.A., Khimani F., Andrades M., Ali S.K., & Paul R. (2008) Reasons for migration among medical students from Karachi. *Medical Educatio, 42,* 61–68.

Terrazas A. (2008). "Indian Immigrants in the United States." Migration Information Source. Migration Policy Institute, Washington D.C. http://www.migrationinformation.org/USFocus/display.cfm?ID=687. Accessed November 12, 2009.

Vertovec S. (2009). *Transnationalism (Key Ideas).* New York: Routledge.

Vertovec S. (2002). *Transnational Networks and Skilled Labour Migration.* Transnational Communities Programme, University of Oxford: Oxford.

Wimmer A & Glick Schiller N. (2002). Methodological nationalism and beyond. Nation state formation, migration and the social sciences. *Global Networks. A Journal of Transnational Affairs, 2(4),* 301-334.

World Health Report. (2006). World Health Organization, Geneva. http://www.who.int/whr/2006/en/index.html

Appendix

1. Recruitment email

International medical graduates from India:

Participate in a 60-minute research interview and earn $50.

If you graduated from medical school in India and are now a resident or licensed physician in California, please consider participating in a research study on the immigration experiences of Indian medical graduates.

To be eligible, you must be an intern, resident, or practicing physician who:

1) was born and raised primarily in India;
2) completed undergraduate medical training in India;
3) immigrated to the US in the past 10 years.

If you are interested in participating, please contact the lead investigator, Christine Henneberg, by phone or by email:

650.815.9800
CHenneberg@berkeley.edu

In your phone or email message, please leave your name, phone number, and a good time to call you back.

Participants will be interviewed at their home or place of work (no travel time for you!), or over the phone. Interviews will take **no more than 60 minutes**. Participants will be asked broad, open-ended questions about their decision to immigrate to the U.S., their experiences working in the US medical system, and their plans for the future. **You will be compensated $50** for your participation in this research.

Based on participants' stories, the aims of this study are to help better support international medical graduates in the United States; improve recruitment and retention of doctors by both India and the United States; and develop sustainable, ethical, and feasible solutions to physician shortages in underserved areas. (You will also be a TREMENDOUS help to a medical student completing her masters' degree at the UCSF-UC Berkeley Joint Medical Program!)

Contact information:

LI: Christine Henneberg
650.815.9800
CHenneberg@berkeley.edu

In your phone or email message, please leave your name, your phone number, and a good time when you can be reached.

PLEASE CIRCULATE WIDELY TO ANYONE WHO MIGHT BE INTERESTED IN PARTICIPATING.

Thank you.

2. Informed consent

UNIVERSITY OF CALIFORNIA AT BERKELEY

BERKELEY • DAVIS • IRVINE • LOS ANGELES • MERCED • RIVERSIDE • SAN DIEGO

SAN FRANCISCO • SANTA BARBARA • SANTA CRUZ

CONSENT TO PARTICIPATE IN RESEARCH

Immigrant narratives: International medical graduates' perspectives on immigration and professional identity

Introduction and Purpose
My name is Christine Henneberg. I am a graduate student at the University of California, Berkeley, working with my Faculty Advisor, Professor Karen Sokal-Gutierrez, in the School of Public Health. I would like to invite you to take part in my research study, which concerns the experiences and future plans of medical graduates from India who immigrate to the United States.

Procedures
If you agree to participate in my research, I will conduct an interview with you at a time and location of your choice. The interview will involve questions about your experiences in medical school and residency, decisions you have made about where to practice medicine and why, and your professional goals and plans. It should last about one to two hours. With your permission, I will audiotape and take notes during the interview. The taping is to accurately record the information you provide, and will be used for transcription purposes only. Notes alone will not be sufficient to conduct the detailed and in-depth analysis of this interview. Therefore if you do not wish to be audiotaped, you will be unable to participate in the study. If you feel uncomfortable at any time during the interview, I will turn off the tape recorder and stop the interview at your request.

I expect to conduct only one interview; however, follow-ups may be needed for added clarification. If so, I will contact you by phone or email to request this. If you agree to a follow-up interview, this interview would be shorter and more directed than the first interview, with questions that will help clarify any details or points of confusion that arose from the first interview, or to inquire about the outcome of any pending decisions from the time of the first interview. Any follow-up interviews would take place within one year of the first interview.

Benefits
There is no direct benefit to you from taking part in this study. It is hoped that the research will be used to better support international medical graduates who are training and practicing medicine in the United States, and to develop feasible, sustainable solutions to the worldwide distribution of physicians and their medical knowledge.

Risks/Discomforts
Some of the research questions may make you uncomfortable, and you are free to decline to answer any questions you don't wish to, or to stop the interview at any time. As with all research, there is a chance that confidentiality could be compromised; however, we are taking precautions to minimize this risk. (*See below for more detail.*)

Confidentiality
Your study data will be handled as confidentially as possible. If results of this study are published or presented, individual names and other personally identifiable information will not be used.

If you would like to give permission for your real name and identifying information to be used in the study, you may indicate this at the bottom of this form.

When the research is completed, I may save the tapes and notes for use in future research done by myself or others. I will retain these records for up to ten years after the study is over.

Compensation
You will not be compensated for participating in this study.

Rights
Participation in research is completely voluntary. You are free to decline to take part in the project. You can decline to answer any questions and are free to stop taking part in the project at any time. Whether or not you choose to participate in the research and whether or not you choose to answer a question or continue participating in the project, there will be no penalty to you or loss of benefits to which you are otherwise entitled.

Questions
If you have any questions about this research, please feel free to contact me. I can be reached at 650.815.9800, or by email at chemneberg@berkeley.edu.

If you have any questions about your rights or treatment as a research participant in this study, please contact the University of California at Berkeley's Committee for Protection of Human Subjects at 510-642-7461, or e-mail subjects@berkeley.edu.

****

CONSENT

You will be given a copy of this consent form to keep for your own records.

If you wish to participate in this study, please sign and date below.

_____
Participant's Name *(please print)*

_____ _____
Participant's Signature Date

Optional:

If you agree to allow your name or other identifying information to be included in all final reports, publications, and/or presentations resulting from this research, please sign and date below.

_____ _____
Participant's Signature Date

3. Interview Guide

Informed consent: I've brought two copies of a consent form. Before we begin, if you would please sign one and return it to me; the other is for you to keep. If you have any questions after we finish today, my phone number and email address are on the form.

Now I'll tell you briefly a little bit about this project: For my master's thesis, I'm researching how international medical graduates from India came to immigrate to the U.S., what their experiences have been in the U.S. medical system, and what their plans are for the future.

If you don't mind, I'll record our conversation and take a few notes while we talk. Unless you signed on the form giving me permission to use your real name, nothing you say in the interview that could be used to identify you will appear in the study.

I'll ask you a few general questions, but you should talk about anything you feel is important, even if I don't ask about it. And if you don't like any of my questions, you don't have to answer them. Because I think people in your position really have a wide range of experiences, I have no real expectations about what we'll talk about.

One more thing: If you want to stop recording at any time, we can turn the recorder off, and then turn it on again later. In fact, I'll put it down right in between us, so you can turn it on and off yourself if you'd like.

Are you ready to get started?

1. INTRODUCTION

First I'll just ask you a little about yourself…

-What kind of doctor are you [training to be]? (Prompt for specialty)

-How long have you been in the US?

-And when did you start your US residency?

-Do you have any family here with you? (Prompt: Are you married? Any children? Where are your parents? Any siblings? Are they in the US, or in India, or somewhere else?)

-Is anyone else in your family a doctor?

2. CURRENT POSITION (*These questions are for practicing physicians who have graduated from their residency. Skip to #3 if the participant is currently a resident.)*

Tell me a little about where you're working now….

-How long have you been working here?

-What specialty are you practicing?

-What kind of hours (full time, part time)?

-Are you working anywhere else?

-How did you come to be working here?

3. RESIDENCY

Tell me a little about your residency so far….

-When did it start?

-How did you come to apply and match to this residency program?

-Are there other international medical graduates (IMGs) in the program? Other IMGs from India?

-Overall, how has your experience working as a doctor in the US been similar or different to what you imagined? (For example, medical specialty and geographic location of your residency, overall experience of adjusting to life in the U.S.)

4. MEDICAL SCHOOL

Now I'd like you to think way back to when you were in medical school and tell me about what it was like for you….

-Where did you go to medical school?

-How old were you when you started?

-Had you always wanted to be a doctor? (Did you consider other careers? Anyone else in your family a doctor?)

-Can you describe what you remember about your clinical experiences as a medical student?

-What else can you tell me about how you remember medical school?

-Did you do any specialty training after graduation? NO.

-Did you practice medicine in India after finishing your training? For how long? What do you remember about it?

5. MOVING TO THE US *(This section might come more naturally or appropriately* after *"Residency and visa application process" questions, depending on whether they applied for*

residency positions while they were in India or after already moving to the US. It is expected that most were already in the US when they applied for residency positions.)

Now I'm going to ask you to think back to the time when you decided to move to the US, and how you made that decision.

-When did you first start to think about moving to the US? (During medical school? Before? After? Had you ever been to the US before?)

-Was it mostly a professional decision, i.e. to do a residency here? Or were there other reasons for you to come?

-What did your family and friends think about your decision to move here?

-Did you have any family members or close friends already in the US?

-If you had to make the decision over again, would you do it again? Why or why not?

-Did you know anyone (friends, family members) who had immigrated to the US for residency before you? What did you know about their experience at that time? What do you know now?

-[*If answer to previous question is positive*]: Were these friends men or women? Do you think being a [man]/[woman]made your experience [similar to]/[different from] theirs?

6. RESIDENCY AND VISA APPLICATION PROCESSES

Now I'd like you to think back to when you were applying for your visa and for residency spots in the U.S.

-Prior to your residency, did you have any hospital experience in the US?

-Where were you working?

-What were your thoughts about the future at that time?

- (So) were you already in the US when you started applying for residency, or were you still in India?

-Can you tell me what you remember about the process?

-Anything in particular that was difficult about the application process(es) for you?

-Where did you turn for help or advice in the process?

-Did you have any friends who had gone through the US residency application process before you, or any friends who were going through the process at the same time as you? Were you able to get help from these people?

-What were your thoughts about the future at that time?

7. PRESENT AND FUTURE

-Has your experience here been more or less what you expected, or has it been significantly different from what you expected? What things have been the same? What's been different? (Prompt for things like medical specialty and geographic location of residency, overall experience of adjusting to life in the U.S)

-Did you always think you would come to the US to stay, or did you think it might be temporary?

-Where and how do you imagine yourself practicing medicine in the future?

-Do you stay in touch with friends, family or colleagues in India? (If so, who? How—phone, internet?)

- Have you been back to India since you moved here? (How many times? What did you do when you went back?)

-In what ways do you feel committed to living and working in the US? (Do you belong to any professional and/or social organizations in the area? Which ones, how long have you participated, what has been your experience so far?)

-In what ways do you feel personally and/or professionally connected to India? (Do you belong to any professional and/or social organizations in India? Which ones, how long have you participated, what has been your experience so far?)

-How much do you think about moving back to India, or to another country?

-What reasons would make you want to move back to India? (Prompt: Would they be reasons to do with your job or your professional goals, or more personal reasons?)

-Do you have any friends who have moved back to India or who talk about it? Are they men or women? How do you think their situation/experiences are [similar to] / [different from] your own?