With and Without the White Coat:

The Racialization of Southern California's Indian Physicians

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Photo Credit: Dave Cochran

For my men in white coats,
Dad and Dave

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Abstract

This study examines the role of occupational status in the racialization of Indian physicians in Southern California. Since the liberalization of U.S. immigration policy in 1965, the number of first and second-generation Indian doctors in the U.S. has grown to nearly seven percent of the nation's physician workforce; however, Indians constitute less than one percent of the total U.S. population. Overrepresented in one of America's most prestigious professions, Indians are more visible in U.S. medicine than in the U.S. at large.

Previous scholarship in immigration research, Asian American Studies, and the sociology of occupations has paid little attention to these professional non-white immigrants and their racial experience in the U.S. Asian American Studies in particular has focused primarily on the racial-ethnic identity formation of economically disadvantaged non-white groups, under the assumption that professional Asian Americans' class status and occupations in the sciences effectively shield them from racist harm and preclude their engagement in racial politics.

This research shows that Indian doctors' high occupational status and class privilege provide them only partial, situational protection from racism. They have what I call occupational citizenship --access to most of the same rights and privileges as whites only when perceived as being both professionally successful and economically beneficial to the U.S. They are clearly marked as occupational citizens during clinical interactions with patients, when they are in the white coat. But outside of this context, they are subject to racist treatment from colleagues, staff, health care institutions, and the general public. The particular forms of racism these doctors face, as well as how they interpret this racism, have as much to do with their gender, immigrant generation, and perception of others' race and class, as with their own professional class status.

These findings are based on fifty-two interviews with first and second generation Indian doctors in Southern California as

well as participant observation at the monthly meetings of two regional Indian medical associations. I also observed seven Indian doctors at work, noting their interactions with patients, staff, and colleagues. Southern California represents an ideal case for understanding the racial formation of Indian physicians in the U.S. because of its large but dispersed population of established Indian physicians, and its overall diversity of race, ethnicity, and class.

Chapter One:

An Introduction to Southern California's Occupational Citizens

As a brown-skinned American, I seldom escape the question: "Where are you from?" My usual response –"My parents are from India"—often leads to another question: "Oh! Do you know Dr. (insert any Indian surname here)? He's from India! And he's just wonderful!" These exclamations, in various forms, have become a common refrain in my life, one I have heard in every U.S. region where I have lived: upstate New York, rural Kansas, the Kansas City area, and Southern California. And although I usually do not know the specific doctor being named, one of the few Indian immigrants I do know well is indeed a doctor: my father.

Why are there so many doctors from India in the U.S., and why do non Indians immediately associate Indians with medicine? Also, what explains the praise that these doctors, unlike so many non-white Americans, receive in public? Are Indian doctors also the victims of U.S. racism? These are questions I often asked myself while growing up and hearing my father both recount the racial prejudice he regularly experienced and also express gratitude for his professional acceptance and success. As a graduate student of race and ethnicity, I hoped to find the answers to these questions in sociological literature on Asian immigrants in the U.S. But the majority of this literature, when it discusses Indian physicians at all, provides only partial answers. It notes the general reasons for the large number of Indian doctors in the U.S., such as the shortage of health care workers in the expanding post-World War II health care economy (Choy 2003: 3, 64, 99; George 2005: 49-50; Portes and Rumbaut 2006: 4), and the lack of professional opportunity these doctors faced in India (Portes and Rumbaut 2006: 75). It also presents them as contemporary immigrant success stories (Helweg and Helweg 1990) –ideal examples of Portes and Rumbaut's concept of

selective acculturation, or the adoption of only those mainstream, white-American practices that result in socioeconomic mobility (Portes and Rumbaut 2001: 54, 102).

However, as Choy (2003b) and Espiritu (2003) argue in their studies of Filipino immigrants, reducing immigration to ideal types and patterns ignores the immigrants themselves, with their deeply felt experiences of success and failure (Choy 2003: 4, 7; Espiritu 2003b: 36). Espiritu notes that these experiences, in the voices of those who lived through them, are often missing in sociological literature on immigration (18). More than a decade has passed since Lisa Lowe's call to see Asian Americans as a heterogeneous community, responding to the multiple contradictions of their U.S. lives through the formation of hybrid identities and cultures (Lowe 1996). Still, many Asian Americans, particularly those with professional careers, remain oversimplified in the scholarship of Asian American Studies and immigration studies. Both fields have mainly focused on the racial experiences of economically disadvantaged non whites, under the assumption that professional Asian immigrants' class status and occupations in the sciences effectively shield them from racist harm and preclude their engagement in racial politics. Koshy (2001) writes:

> [I]ncoming middle- and upper-class Asian immigrants' … class status often insulates them from the harshest effects of the experiences from which the antiracist discourses of the civil rights movement derive, and their educational (generally in the sciences) and career paths often bypass the arenas where the politics of race is engaged in a sustained way. (192)

After reading this statement for the first time, I immediately thought of my father, whose daily professional interactions did not always insulate him "from the harshest effects of the experiences from which the antiracist discourses of the civil rights movement derive." Although not always the direct victim of these effects, he saw their impact on the racially diverse community of patients, colleagues, and staff

with whom he worked. In interacting with this community, he could not afford to "bypass the arenas where the politics of race are engaged," and, while he himself did not engage these politics "in a sustained way," his experiences inspired me to do so. Koshy's words became a challenge. I wanted to know if my father's experiences were unique, or if other Indian doctors in the U.S. had also experienced race in more complicated ways than Koshy and others acknowledged.

This study is my attempt to correct the overly simplistic representation of Indian physicians' racial experience in the U.S. From May 2006 to November 2007, I studied the Indian medical community of Southern California, interviewing 52 of its first and second-generation members –that is, doctors who grew up and completed medical school in India before moving to the U.S. (the first generation) as well as doctors of Indian descent who grew up primarily in the U.S. (the second generation).[1] I also observed the monthly meetings of two of the three Indian Doctors' Clubs (IDOCs)[2] in the region, and shadowed seven of the interviewed doctors at work –noting their interactions with patients, staff, and colleagues. Three main questions guided my research:

1. What are the professional motivations, histories, and narratives of post-1965 Indian physicians in Southern California, and how do they vary according to immigrant generation and gender?[3]
2. How do Indian physicians interpret their inter-ethnic relations with staff and patients in various professional contexts? And how do these interpretations affect both the physicians' gendered ethnic identities and their perceptions of non Indians' gendered ethnic identities?
3. How do Indian physicians interpret their relationships with patients in terms of the traditional Western doctor-patient hierarchy of patient submission to physician authority, and how do these interpretations vary according to the doctors' immigrant generation and their gender?

My study revealed that Indian doctors' occupational status defines their U.S. lives. Indeed, it was the first generation's primary motivation for immigrating to the U.S., which actively recruits International Medical Graduates (IMGs) to fill physician shortages (Boulis and Jacobs 2008: 29, 43, 196). The doctors' occupational status becomes their master identity in the U.S. and accords them a significant amount of authority over patients of all races and ethnicities. But outside of clinical spaces, and among those who share some of their occupational knowledge and expertise, the doctors' non-white racial status and gender define them more than their profession, which does not visibly mark them as the highest medical authority in the room.

Indian doctors' high occupational status and class privilege, therefore, provide them only partial, situational protection from racism. They have what I call occupational citizenship -- access to most of the same rights and privileges as whites only when perceived as being both professionally successful and economically beneficial to the U.S.[4] The social prestige attached to their occupation --assumed to bestow noble ideals of healing, not harming, to all its practitioners (Dickstein and Hinz 1992)—generally legitimates their presence in public contexts and accords them an honorary white or model minority status. These doctors are clearly marked as occupational citizens during clinical interactions with patients, when they are in the white coat. But outside of this context, they are subject to racist treatment from colleagues, staff, health care institutions, and the general public. The particular forms of racism these doctors face, as well as how they interpret this racism, have as much to do with their gender, generation, and perception of others' race and class, as with their own professional class status.

I situate the concept of occupational citizenship at the intersection of three areas of scholarship: studies of immigration, Asian American Studies, and the sociology of work and occupations. In the next three sections, I show that Indian doctors' racial formation –the processes by which they

have come to be characterized as a non-white minority (Omi and Winant 1994)-- is more complicated than any one area maintains. Understanding and explaining these doctors' inclusion and exclusion in white America requires a dialectical framework built upon the theoretical foundations of sociological studies in all three areas.

Assimilated But Not Fully Accepted: Studies of Immigration

Traditionally concerned with the assimilation of recent immigrants, sociological studies of immigrants measure the social acceptance of these immigrants according to their parity with native-born whites, particularly their socioeconomic parity. Classic assimilation theories, based on the early twentieth-century experiences of European immigrants, predict that professional immigrants quickly experience social equality with white Americans (Alba and Nee 2003: 21, 24, 28; Bacon 1996: 11; Burgess 1925: 56; Gordon 1964: 80-81; Park 1926: 9, 18). The ethnic identity of these white immigrants becomes merely symbolic (Gans 1979; Waters 1990: 7) as they begin to identify with their white-American peers and experience social citizenship in the U.S. –what T.H. Marshall described in 1949 as "a share in the full social heritage and to live the life of a civilized being according to the standards prevailing in the society" (Marshall 1964: 78).

Studies of middle-class Asian immigrants in the U.S. have shown that they are also quickly achieving, if not surpassing, socioeconomic equality with their white-American peers, succeeding in traditionally white professional institutions and settling in predominantly white suburbs (Purkayastha 2005a: 1; Tuan 1998: 7, 30-35). Compared to many other non-white immigrant groups, Asian immigrants appear to be "honorary whites" –destined, like the European immigrants of the early twentieth century, for full membership in the white-American mainstream (Bonilla-Silva 2006: 179, 180; Kim 1998; Tuan 1998: 31). While poorer non-white immigrants are at risk of assimilating into the underprivileged Black and Latino

segments of U.S. society, middle-class Asians appear to assimilate into the white middle class sector, at least socioeconomically (Portes and Zhou 1993).

Nevertheless, Portes and Zhou's segmented assimilation theory (1993) as well as several studies of middle-class Asian immigrants (Espiritu 2003b, Kibria 2002, Park 2005, Purkayastha 2005a) argue that despite their structural assimilation into the white middle class, these immigrants' ethnic identity remains strong and they do not experience full social citizenship in the U.S. As mentioned above, studies of U.S. immigrants hold up middle-class Asian immigrants as models of selective acculturation, retaining cultural values, practices, and communities that help them resist downward assimilation into the non-white poor but adapt to the norms of white America's educational and professional institutions (Portes and Zhou 1993; Portes and Rumbaut 2001: 54, 102). In this conceptualization of Asian immigrants, the immigrants themselves appear to be the principal agents of their socioeconomic destinies, selectively assimilating and maintaining their ethnic cultures so as to avoid racial prejudice and discrimination.

An underlying assumption of segmented assimilation and selective acculturation theories (which are, after all, rooted in the theory of classic, straight-line assimilation) is that the success of socioeconomically well-adapted immigrants results more from factors internal to the immigrant community than from factors external to it. While both theories emphasize the social context and reception of the host society as being integral to an immigrant group's trajectory of assimilation, the host society often receives marginal attention in discussions of socioeconomically successful Asians (Kim 2008: 2, 4, 5; Purkayastha 2005a: 9). The main focus of these discussions is the middle-class immigrants' cultural and community response to host society structures, not the structures themselves.

Specifically, racialization –or the ways in which the host society categorizes a group as being fundamentally different and separate from itself (Omi and Winant 1994)—is rarely

placed at the center of immigration scholarship on middle-class Asians (Purkayastha 2005a: 9). The implication is that racialization is not central to the lives of these immigrants, if they share so many class-based similarities with middle-class whites. Kim (2008) --one of a handful of immigration scholars to place racialization at the center of her study of middle-class Asian immigrants[5]-- notes:

> …social class is neither the only key axis of assimilation nor a ticket out of institutionalized and everyday racial barriers…. [S]ocial class is but one mark of social inequality. There are myriad factors that preclude full membership in the mainstream United States culture and the national identity. For instance, as long as Asian Americans continue to be associated with Asia, they do not escape racial bias simply because they have made it into the White American middle class (4-5).

Indeed, like the middle-class Korean immigrants of Kim's study, the professional Indian immigrants of my study also demonstrate their agency by selectively mobilizing ethnic and cultural resources to assimilate into the white American middle class. In Chapters 5 and 6, I discuss how Indian doctors strategically reject and rely upon Indian cultural frameworks to structure their response to U.S. social hierarchies. However, these doctors also find that despite their class status and ethnic cultural capital, they consistently encounter racial bias. Thus, theories of assimilation explain only part of Indian doctors' U.S. experience. As I argue in this dissertation, the doctors are defined not only by their high socioeconomic status, but also by their race.

When Racial Ambiguity Trumps Class-Based Agency: (South) Asian American Studies

Unlike studies of immigration, Asian American Studies focuses on race as the defining characteristic of Asian Americans' lives, whether they are first-generation immigrants or the U.S.-born descendants of foreign-born immigrants. Rooted in the Third

World student movements of the 1960s and 1970s (Min 2006: 3), Asian American Studies sees racial exclusion as the core of the Asian-American experience. Originally a Marxist enterprise, this field of study initially interpreted racial exclusion as a function of capitalist exploitation, positing that racial oppression is a symptom of socioeconomic disadvantage (Hirabayashi and Alquizola n.d.; Chan 2005: 38). Thus, until recently, Asian American Studies centered primarily on socioeconomically marginalized Asian Americans, such as laborers (Glenn 1986, 2002; Kwong 2000; Takaki 1998; Zhou and Nordquist 2000), ethnic community entrepreneurs (Abelmann and Lie 1997; Kim, K.C. 1999; Lee 2000; Light 1988), and refugees (Canniff 2001; Chan 2004; Vo 2000). When mentioned, Asian American professionals usually served to exemplify the persistence of corporate "glass ceilings" or as proof that Asian Americans are not "model minorities" experiencing full socioeconomic equality with whites (Cheng and Yang 2000, 473-76; Chou and Feagin 2008; Fong 2009). But the perspectives of the professionals themselves, regarding their occupational status, were rarely included.

In recent years, several studies have examined the occupational perspectives of Asian American professionals in terms of their ethnic identity formation (Bhatia 2007; Dhingra 2007; Ho 2003; and Kim and Min 2000). These studies have foregrounded the professionals' selective and strategic expressions of their ethnic identities in white-American professional spheres. Much like scholarship on Asian immigrants' selective acculturation, the current research on Asian American professionals highlights their agency in negotiating the racial and ethnic hierarchies they encounter at work. But the hierarchies themselves, and the specific ways they manifest in the professionals' working lives, receive marginal attention.

Also currently marginalized in Asian American Studies are the many Asian American professionals who work in occupational sectors, such as medicine, without clearly defined

corporate hierarchies. Doctors and lawyers, for example, don't necessarily work under someone of a recognizably higher occupational status. And Indian doctors and engineers, particularly information technology professionals, are not racially or ethnically underrepresented in their occupational field. Indeed, as nearly 7% of U.S. physicians but less than 1% of the U.S. population, Indians are overrepresented in medicine (NAIDA 2009; AMA 2009b; LIFS 2009a; U.S. Census Bureau 2009). Several doctors I interviewed said that they don't feel like numerical minorities in medical institutions. My study considers how these Asian American professionals experience racial discrimination at work, thus challenging the assumption that all Asian American professionals are the underrepresented employees of white-dominated corporations.

South Asian American Studies has also paid scant attention to the racial formation of professional South Asians in multiple U.S. contexts. Although concerned primarily with professionals –over fifty percent of the South Asian American population (Rao 2003; Reeves and Bennett 2004: 14)-- this small but burgeoning subfield has focused on the identity formation of South Asians within co-ethnic contexts, such as organizations and events for and by Indian immigrants and their American children (Bhattacharjee 1998, Kurien 2007, Maira 2002, Rudrappa 2004). Studies of these ethnic spaces show that a professional status grants South Asian Americans, especially first-generation males, the agency to take advantage of contemporary U.S. multicultural politics and assert an ethnoreligious "Hindu Indian" identity of their own construction (Bhattacharjee 1998, Kurien 2007, Rudrappa 2004). The hegemonic power of first-generation Indian male professionals within their co-ethnic community is a phenomenon I also observed among Southern California's Indian physicians; and I explain its effects on first and second-generation Indian female doctors in Chapters Four and Six.

Missing from these studies, however, is an analysis of professional Indians' racialization and racial identity formation in settings where their ethnic, religious, and racial identities

remain ambiguous and unknown. As several scholars of South Asian American Studies note, in public, South Asians are more likely to be racially lumped with America's most marginalized groups --Blacks, Latinos and Middle Eastern Muslims-- than with model-minoritized East Asians whom they don't physically resemble (George 1997; Joshi 2006; Maira 2002; Purkayastha 2005a). As I show in Chapter Four, outside of co-ethnic spheres, Indians are seen as "ambiguous non whites" (Kibria 1996) before they are seen as middle-class professionals.

My study shows that first-generation doctors come to interpret their racial ambiguity not only in terms of the social strata and hierarchies of the U.S. but also in terms of the social structures of India –a transnational perspective rarely taken in South Asian American Studies, or in Asian American Studies as a whole. With the notable exception of Kim's work on the racialization of Korean Americans in Los Angeles (2008), the assumption underlying most scholarship in Ethnic, Immigration, and Asian American Studies is that immigrants' proficiency in the social frameworks of their homelands will quickly yield to an appreciation of U.S. social structures (Espiritu 1992; Foner 2000; Kim, C.J. 1999; Omi and Winant 1994; Portes and Rumbaut 2001; Waldinger 2001). My analysis of how first-generation Indian immigrant doctors interpret their U.S. racialization challenges this assumption, showing that these professionals depend on the hierarchical caste framework of India to structure their understanding of the racial prejudice and discrimination they experience in the U.S.

My dissertation, therefore, expands the racialization framework at the heart of Asian American Studies to include ambiguously raced South Asian professionals in both occupational and non-occupational public settings. Analyzing the experiences and perceptions of the professionals themselves, I demonstrate that their class-based agency to define their racial formation is limited, especially in those public spaces where their race and gender are more visible than their occupational status. Furthermore, I show that when

defining their racial status in the U.S., first-generation Indian immigrant doctors rely on their knowledge of Indian social hierarchies as much as their familiarity with U.S. social strata. Thus, my research presents a challenge to the Marxist, U.S.-centric assumptions on which Asian American Studies has traditionally been based.

Of Medical Professionals, Not Just Medicine: The Sociology of Occupations and Medical Sociology

My research also presents a challenge to the sociology of work and occupations, including research in the area of medical sociology. In discussing professions such as medicine, the sociology of work and occupations has focused on the structure, organization, and power of these professions as institutions (Abbott 1988, Abbott and Meerabeau 1998, Berlant 1975, Freidson 1970, Larson 1977, Saks 1995, Sciulli 2008). Medicine as a whole is the unit of analysis, not medical professionals themselves. This top-down examination of U.S. medicine provides a social and historical context for the profession's rise in status and influence, and also helps to situate its politically constructed role in relation to other occupations (Abbott 1988). The sociology of occupations thus explains the social hierarchies that determine Indian doctors' high socioeconomic and professional status in the U.S. It also describes the structural changes –such as nationwide reforms in health care and medical education (Mechanic 2003; Tanne 2007; Starr 1982)—that have led to the current growth and distribution of Indian doctors in U.S. medicine.

But how U.S. doctors themselves, of any ethnicity, experience and perceive these structural changes in medicine has received little attention in sociological studies of the professions, including Medical Sociology. As in immigration research and Asian American Studies, empirical studies analyzing the professional experiences of physicians, described in their own words, are lacking in the sociology of work and occupations. Again, the underlying assumption is that

physicians, who represent the top rung of the U.S. occupational ladder (Boulis and Jacobs 2008: 7; Cockerham 2004: 207), are all primarily and equally defined by their prestigious professional status. Sociologists often interpret this high professional status to supersede differences in race, class, religion, gender, national origin, sexuality, and medical specialty among physicians –even to minimize or erase these differences (Becker 1961; Boulis and Jacobs 2008). The sociology of occupations and medical sociology suggest that American physicians are a cohesive, united community who all experience gains (and losses) in occupational power and status in similar ways (Cockerham 2004: 211).

Although medical sociologists have begun to study diversity among U.S. physicians (see Boulis and Jacobs 2008; Hammond 1980; Hinze 1999; Hoff 1998, 2004; Lorber 1984, 1993, 1997; Martin, Arnold, and Parker 1988; Riska and Wegar 1993), they have mostly compared and contrasted the experiences of male doctors to female doctors, who are now 48.9% of U.S. medical students (Boulis and Jacobs 2008: 2). These medical sociologists have sought to determine whether (and when) the female doctors occupy a subordinate status within the medical profession, thus questioning the assumption that all U.S. physicians enjoy the same occupational prestige and equality. Occupational segregation by sex has become a recognized and studied aspect of the medical profession.

The occupational segregation of doctors by race, however, remains a largely uninvestigated subject in medical sociology, even though 22% of U.S. physicians are not white (Boulis and Jacobs 2008: 46). The few studies that pay attention to U.S. physicians' race are mainly interested in how a doctor's race affects patient treatment and satisfaction (Cooper-Patrick et al. 1999; Escarce 2005; Johnson et. al. 2004; LaVeist and Nuru-Jeter 2002; Saha et. al 2000; Stinson and Thurston 2002; van Ryn and Burke 2000; and West 1984). Race is studied in the context of doctor-patient interactions. In this context, the doctor nearly always has situational authority, regardless of race

(Atkinson 1995; Cockerham 2004: 148, 190; Parsons 1951). Unlike research on gender differences among medical professionals, research on the racial diversity of doctors has yet to complicate the premise of occupational equality among physicians. A vertical, top-down approach still structures studies of racial difference among U.S. physicians. A horizontal approach concerned with intra occupational race relations seldom appears in sociological research on doctors.[6]

Also lacking is an intersectional approach that considers how multiple social factors together determine the intraoccupational status of doctors. Feminists of color have long recognized the importance of intersectionality –or the convergence of more than one social disadvantage (such as a non-white race, female gender, and lower than middle-class background)—in defining their subordinate status in the U.S. (Anzaldúa 1987; Collins 2000; Chow, Wilkinson, and Zinn 1996; Crenshaw 1989; Combahee River Collective 1977; Hurtado 1996, 2003; Moraga 1981; and Sandoval 2000). And scholars of immigration studies and Asian American Studies often take an intersectional approach when analyzing the experiences of disenfranchised women of color (Espiritu 2008; Glenn 1986; Hondagneu-Sotelo 2007; Salazar Parreñas 2001). In this dissertation (particularly Chapter Three), I show that an intersectional approach is also applicable to the sociological study of non-white professionals, who, although not disadvantaged by class, still experience both racial and gender subordination, often from colleagues in the same occupation.

This study of Indian doctors, therefore, brings the sociology of occupations and medical sociology into dialogue with studies of immigration and Asian American Studies –three areas of scholarship that rarely meet. It recognizes the socioeconomic assimilation of these non-white physicians – their defining characteristic in research on immigration— without denying their racialization. It also considers those contexts in which their racial ambiguity trumps their class-based privilege in determining their ethnic identity formation,

thus expanding the racialization framework at the heart of Asian American and South Asian American Studies. Finally, it demonstrates that occupational status alone does not determine these doctors' professional experiences but intersects with race and gender to distinguish their experience of U.S. medicine from that of white-American male doctors. Overall, it calls attention to a diverse but understudied community of the U.S.: its medical professionals.

The Indian Doctors of Southern California

The Indian medical community of Southern California –a large region comprising five counties (including Los Angeles and Orange Counties) (Ryan, Wilson, and Fulton 2004: 309)-- represents an ideal case for understanding the racial formation of Indian physicians in the U.S. There are two main reasons I chose to interview and observe Indian doctors in this region: 1. its large but dispersed population of established Indian physicians; and 2. its overall diversity of race, ethnicity, and class. I explain each of these reasons below.

Large, Dispersed, and Established. Long known as an immigrant destination of the U.S. (Bohn 2009), California has been recruiting International Medical Graduates (IMGs) to fill its physician shortages since the 1960s, when baby boomers' increasing health care needs coincided with the liberalization of U.S. immigration policy (Hayes-Bautista 2000). More than forty years later, Southern California hospitals regularly appear on lists of IMG-friendly medical residency programs in the U.S. (DigitalDoc 2007, aajkal 2007). And with 25,408 practicing IMGs, California is the state with the second largest population of IMG physicians in the nation (AMA 2009a), most of whom (47,581 or 19.9% of U.S. IMGs) received their medical degrees in India (AMA 2008b). (New York, with 35,180 practicing IMGs is the state with the largest IMG population in the U.S.).

Southern California alone is home to 2,082 South Asian physicians (first and second generation) as well as three Indian

Doctors' Clubs (IDOCs). All three IDOCs are affiliated with the National Association of Indian Doctors in America (NAIDA) --the largest ethnic medical organization in the U.S., second in size only to the American Medical Association (NAIDA, 2009).[7] (In this dissertation, I have given pseudonyms for all four organizations). IDOCs are associations formed to represent and fulfill the professional, social, and cultural interests of Indian physicians in the U.S. The largest and oldest of Southern California's three IDOCs, the Orange County Indian Doctors' Club (OC-IDOC), was founded in 1979 --two years before the founding of NAIDA—and claims over half of Orange County's 500 Indian physicians as its "life members" (U.S. Census 2000, OC-IDOC 2005).[8] As a large, established IDOC, therefore, OC-IDOC is quite involved in NAIDA, in which several of its first-generation male members have held leadership positions. In fact, the NAIDA President during the 2006-2007 term –the year in which I conducted my field research—is a member of OC-IDOC.

Although consisting primarily of first-generation Indian immigrant physicians, OC-IDOC and its two smaller Southern California counterparts –The Los Angeles Indian Doctors' Club (LA-IDOC) and The Three Valleys Indian Doctors' Club (TV-IDOC)[9] —also represent the rapidly growing population of second-generation Indian physicians in Southern California. I define the second generation as those Indian-American doctors who grew up primarily in the U.S. and completed most of their education in the U.S. as well.[10] Many of these young physicians in their twenties and thirties belong to the Emerging Doctors sections[11] of Southern California's IDOCs and NAIDA --designed to bring together medical students, residents, and fellows for networking, socializing, and mentoring from more established Indian immigrant physicians (NAIDA 2007). According to NAIDA's Emerging Doctors Section, approximately 10,000 or ten to twelve percent of medical students in the U.S. are of South Asian origin –a significant percentage considering that less than one percent of